

EFFECTIVENESS OF A PSYCHOEDUCATIONAL INTERVENTION FOR MIDLIFE
ADULTS WITH PARENT-CARE RESPONSIBILITIES

BY

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This dissertation, and the completion of my doctoral degree, is dedicated to my grandfather, Mr. Matthew R. Babb. Without his constant encouragement and support, this goal would never have become a reality. He was, and is, always there to share honest advice and unconditional love. He has given me far more than he will ever know and it is with deep gratitude and love that I dedicate this dissertation to him.

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Despite the identification of counseling needs and correlated outcome measures, little has been done to develop testable intervention strategies based on these needs for midlife adult children caring for aging parents. The purpose of the current study was to develop, implement, and evaluate a psychoeducational group intervention which addressed the needs of this population. The intervention included 7 males and 44 females, between the ages of 54 and 72, who were currently responsible for the care of a parent who was aged 60 or older. The intervention consisted of four, 2-hour sessions. Variables which were measured included: knowledge (Facts on Aging Quiz - Revised), emotional support (Caregiver Burden Inventory), and skill development (Coping Resources Inventory for Stress). A delayed treatment, control group design with follow-up after a four week interval was utilized.

Significant increases were found at the .05 level for knowledge, overall coping resources, and self-disclosure following group participation. Implications for future interventions are discussed.

CHAPTER I INTRODUCTION

Demographic data indicate that the population of persons aged 65 and older is growing at an increasing rate. Approximately one-third of all older persons are impaired to the extent that they require some form of supportive services to remain in the community (Brody, 1974; Callahan, Diamond, Giele, & Morris, 1980). Researchers have documented that family members, particularly adult children, provide the majority of assistance to impaired older persons (Brody, Poulshock & Mascioachi, 1978). Adult children caring for aging parents may be faced with developmental issues of midlife as well as stresses related to the caregiving role. Counselors address stress and other emotional issues from a developmental perspective. Therefore, counseling interventions are needed which counselors can utilize to meet the increasing needs of midlife adult children caring for aging parents (Myers, 1989). The purpose of the current study was to construct, implement, and evaluate the effectiveness of a counseling intervention designed to meet the needs of adult children caring for aging parents.

Demographic changes in the population over age 65 are having a profound impact on American society. At the turn

of the century, 4.1% of the United States population was age 65 and over. By 1988, this number had grown to 12.4% of the total population (U.S. Administration on Aging, 1989). Population projections indicate this group will continue to grow to 21.8% of the total population by 2030 (U.S. Bureau of the Census, 1984). These changes do not solely reflect a growth in numbers in this segment of the population but a growth in proportion as well. In the last 20 years, the over 65 population increased by 24% compared to a 6% increase in those under age 65 (Special Committee on Aging, 1983). Of the over age 65 group, those age 85 and older are now, and are expected to remain, the fastest growing age segment in the total population. Furthermore, the number of persons aged 85 or older has increased 23 times since 1900; the number of persons aged 75 to 84 has increased 12 times; and the number of persons aged 65 to 74 has increased 8 times. It is estimated that by the year 2010, there will be 6.8 million persons over age 85 or 2.4% of the total population (U.S. Administration on Aging, 1989).

The importance of these demographic data is reflected in a national study of well-being in older persons, which reported a tremendous rise in general impairment levels corresponding to increases in age. According to this report, only 6.3% of the United States population under age 70 are extremely impaired, while 9.3% of those between the ages of 75 and 79 and 22.5% of those over age 85 are

classified as extremely impaired (Federal Council on Aging, 1978).

As noted earlier, approximately one-third of all older persons are impaired to the extent that they require some form of supportive services (Brody, 1974; Callahan, Diamond, Giele, & Morris, 1980; National Center for Health Statistics, 1979). Although approximately 5% of impaired older persons are cared for in institutions, most impaired older persons remain in the community with assistance from caring family members (Brody, Poulshock & Mascioachi, 1978; U.S. Administration on Aging, 1989).

Family caregiving accounts for an estimated 80% of all care provided to impaired older persons (Brody, Davis, Fulcomer & Jonsen, 1979). The caregiving relationship is differentiated from typical family exchanges and is defined by the existence of some degree of impairment on the part of the older person which limits independence and necessitates ongoing assistance (Horowitz, 1985). Furthermore, while the family system is often referred to in the literature as providing care, research has documented that one family member usually occupies the role of primary caregiver and is the primary provider of direct assistance (Horowitz, 1985). The identity of the primary caregiver follows a hierarchial pattern: a spouse, if there is one available and capable, and an adult child (usually a daughter) if there is not (Arling & McAuley, 1983; Cantor, 1983).

Recently, midlife adult children of aging parents have been identified as the "sandwich generation" because their needs are caught between the needs of their adolescent children, who are seeking independence, and the needs of their aging parents, who may become increasingly dependent (Miller, 1981). Adult children who are caregivers may experience emotional, physical and financial stresses related to the caregiving role (Cantor, 1983; Cicirelli, 1980). In the absence of respite, such stresses may become debilitating. Counselors can play an important role in helping to reduce the perceived stresses of caregiving, thus enabling adult children to continue providing care and preventing unnecessary or premature institutionalization of aging relatives. Therefore, counseling interventions are needed which counselors may utilize to meet the needs of midlife, adult children caring for aging parents.

The remainder of chapter I is divided into six sections. These include historical overview, statement of the problem, purpose of the study, research hypotheses, definition of terms, and organization of the study.

Historical Overview

Research on family caregiving began in the 1930s and has been receiving increasing attention in recent years. The theme of family abandonment dominated the professional literature from the 1930s through the late 1950s. In 1944, Talcott Parsons hypothesized that the American family was

contracting and becoming more specialized. Furthermore, he identified the isolated nuclear family (husband, wife and minor children) as the most distinctive feature of the American kinship system (Parsons, 1944). This trend was thought to be due to increasing industrialization, urbanization, and geographic mobility which threatened the viability of the family (Horowitz, 1985).

Research which began in the 1960s challenged the myth of family abandonment of older persons and firmly established the continued existence of the modified extended family as the modal family structure in American society (Litwak, 1965; Sussman, 1965; Sussman & Burchinal, 1962). Furthermore, this time period was characterized by large scale social surveys of the general aged population which documented the type, frequency, and nature of kin interactions and exchanges (Shanas, 1968, 1979a, 1979b).

More specifically, studies conducted in the 1960s and 1970s documented that over half of all older persons are married, 70% share a household with another family member, 80% have at least one living child, and 80% have siblings. Only 3% of non-institutionalized older persons can be considered kinless (Shanas, 1979a, 1979b; Shanas, Townsend, Wedderburn, Friis, Milhoj, & Stehouwer, 1968; Troll 1971). The importance of family relationships in the lives of older persons is indicated not only by the availability of family members but by their proximity, patterns of contact, and

mutual aid, as well as by affective relationships (Troll, 1971).

According to Shanas (1979a), 84% of older persons reside close (within one hour's travel time) to at least one adult child. More than 75% of older persons reported seeing an adult child at least once a week and approximately half reported seeing an adult child daily (Cantor, 1975; Shanas, 1979b). Additionally, several studies have documented that intergenerational family relationships are largely characterized by the presence of mutual aid and affection (Bankoff, 1983; Bromberg, 1983; Cantor, 1975; Cheal, 1983; Harris & Associates, 1975; Lee & Ellithorpe, 1982; Sussman, 1965; Sussman & Burchinal, 1962).

As the health and/or financial status of the older person decreases, this pattern of mutual assistance begins to shift. It is at this point that the family has been found to be the major provider of services and has emerged as the primary caregiver to impaired older persons (Shanas, 1979b).

Caregiving can consume enormous amounts of time, energy, and both financial and emotional resources. Hence, research in the mid-1970s began to focus on the consequences of providing care for the family unit. While the family system is often referred to in the literature as providing this care, research has documented that one family member usually occupies the role of primary caregiver and is the

primary provider of direct assistance (Horowitz, 1985). Shared responsibility for primary caregiving between two or more family members or friends is very rare. In fact, other family members and friends, if involved, usually play a secondary role in caregiving (Cantor, 1980, 1983; Frankfather, Smith & Caro, 1981; Johnson, 1983; Johnson & Catalano, 1981; Stroller & Earl, 1983).

There seems to be a clearly established, hierarchial pattern which establishes who provides care. This pattern begins with the spouse, if there is one available and capable, and an adult child (usually a daughter) if there is not. If spouse and children are absent, other relatives (siblings, grandchildren, etc.) will take on the role of primary caregiver (Arling & McAuley, 1983; Cantor, 1983; Johnson, 1983; Johnson & Catalano, 1981; Keith, 1983; Kivett & Learner, 1980; Shanas, 1979a, 1979b; Stroller, 1982; Stroller & Earl, 1983; Tobin & Kulys, 1981). Additionally, females predominate over males in each kin category (Brody, 1981; Cantor, 1983; Johnson, 1983; Stroller, 1982;; Troll, 1971; Troll et al., 1979).

Given the demography of family structure and gender differences in life expectancy, the usual caregiver for the older man is his elderly wife and for an older woman, her adult middle-aged child (usually a daughter). Because women over age 85 outnumber men by a ratio of approximately 2:1 (Butler & Lewis, 1982), it becomes clear that middle-age

children provide a very significant proportion of caregiving to older women in particular. Because caregiving can be both time consuming and stressful (Horowitz, 1985), it is important to examine the impact of providing care on adult children. A discussion of adults in midlife, found in the following section, can contribute to an understanding of the impact of caregiving on adult children.

Adults in Midlife

Adults in midlife can be defined as persons who are between 40 and 70 years of age. This group has been referred to as the "command generation" because they occupy positions of power and authority (Neugarten, 1968). They have also been called the "sandwich generation" because their needs are caught between the needs of their adolescent children, who are seeking independence, and the needs of their aging parents, who may become increasingly dependent (Miller, 1981).

Midlife is a period when individuals move toward decreased status (Riley, Foner, Hess, & Toby, 1969). During the midlife period, most persons experience a peak in their occupational status, earning capacity, and career mobility. At the same time, midlife adults are also faced with their own mortality. This is precipitated by a shift in time perspective. Many persons in midlife begin to view life in terms of time left to live rather than time since birth (Neugarten, 1968). Furthermore, physical changes and

declines, recognition of reduced energy levels, and the aging of one's parents may stimulate a reevaluation of one's life goals (Myers, 1989).

According to Buehler (1967), midlife is a time for self-assessment. It is a time for evaluation of one's life, goals, and accomplishments. For some persons, it may be a time to make now-or-never changes and to set and begin striving for new goals. Thus, the midlife transition is characterized by taking stock of one's life and planning for the future (Gould, 1978; Myers, 1989; Schlossberg, 1984).

Additionally, life span developmental theorists have identified various developmental issues associated with the period of midlife. For example, Havighurst (1948) describes seven tasks of midlife: achieving adult civic and societal responsibility, establishing and maintaining an economic standard of living, assisting teen-age children to become responsible adults, developing adult leisure activities, relating oneself to one's spouse as a person, and accepting the physiological changes of middle age. According to Erikson (1963), the central theme of midlife is achieving a sense of generativity (providing for offspring and assisting and guiding the next generation).

During midlife, as children begin to leave home, identity issues may become significant, particularly for women. Many women may begin or resume careers during this time. Intimacy issues also begin to emerge during midlife

as couples begin to relate to each other without children present (Brody, 1981).

In summary, transitions of midlife include the potential for independence, self-direction, and pursuit of goals postponed during the child-rearing years (Myers, 1989). However, these newly discovered freedoms may be interrupted as the needs of aging parents increase. Adult children in midlife may find themselves pulled in many directions, needing to set priorities for the use of their limited time and resources. Among the conflicts they face is the crisis of filial maturity, discussed below.

Adult Children in Midlife

Filial maturity refers to the capacity to accept one's aging parents and to fulfill their need for help and support. The issue of filial maturity usually becomes significant in middle age. It is during this time that adult children may begin to truly appreciate their parents and see the relevance of their parents' lives to their own (Blenkner, 1965, Troll et al., 1979).

Although the development of filial maturity is important for both middle age children and their aging parents, there are several issues which make attainment of this goal difficult. These include: the prevalence of negative stereotypes related to aging (Myers, 1988), the continued presence of the myth of abandonment (Shanas, 1979a), the recognition of one's own aging through the aging

of parents (Myers, 1988), and the lack of appropriate role models for relating to aging parents (Dobson & Dobson, 1985).

Adult children in midlife may be confronted with several developmental tasks related to midlife while struggling to achieve filial maturity. Adult children in midlife whose parents become increasingly impaired and dependent may be faced with additional emotional, physical and financial strains related to the caregiving role or fear of being placed in that role. In order to understand the impact of the caregiving role on midlife adult children caring for aging parents, the consequences of caregiving are discussed below.

Midlife Adult Children as Caregivers

As discussed previously, midlife adult children provide a large majority of the care received by aging parents. Although the actual tasks performed can range from occasional errands to around-the-clock care, it is clear that the provision of care has an impact on the caregiver. There are both costs and benefits associated with caregiving, although the literature has focused largely on the former (Horowitz, 1985). It is important to note, just as the types and extent of care provided vary, so do reactions to the caregiving experience. Therefore, everyone will not necessarily experience each of the consequences discussed here.

Negative consequences associated with caregiving are documented in several areas including emotional, physical and financial stresses. Consistently, findings across studies have documented that emotional stresses associated with the caregiving role are the most pervasive and the most difficult for the caregiver to deal with when compared to physical and financial aspects of care (Cantor, 1983; Cicirelli, 1980; Horowitz, 1982). Additionally, increased levels of depression, anxiety and lower morale have been documented among caregivers (Gurland, Dean, Gurland & Cook, 1978; Rabins, Mace, & Lucas, 1982; Robinson & Thurnher, 1979).

Contributing to the emotional stresses of caregiving are the restrictions on time and freedom associated with caregiving responsibilities. Disruption of domestic routines, decreased personal time, less time for social and leisure activities, inability to take vacations, rearrangement of work schedules, and restricted mobility are all common indicators of caregiver stress (Archold, 1980, 1983; Arling & McAuley, 1983; Cantor, 1983; Frankfather et al., 1981; Horowitz, 1982; Poulshock & Deimling, 1984; Rabins et al., 1982). Furthermore, these restrictions often affect long-range plans for retirement and/or relocation (Archold, 1983; Horowitz, 1982).

Caregiving also impacts marital and family life. Spending time away from families and neglecting family

responsibilities have been documented to be common concerns for many caregivers (Archold, 1983; Arling & McAuley, 1983; Horowitz, 1982). Increased family conflicts and disrupted family relations associated with the caregiving role have been reported (Poulshock & Deimling, 1984; Rabins et al., 1982), as well as strained affective relations between caregivers and the dependent relative (Archold, 1983; Cantor, 1983; Frankfather et al., 1981; Johnson & Catalano, 1983; Robinson & Thurnher, 1979).

As noted above, benefits of the caregiving role have been largely neglected in the literature. However, the evidence suggests that caregivers can identify at least one positive aspect associated with providing care when asked directly. This aspect usually involves a feeling of self-satisfaction and self-respect stemming from the knowledge that one is successfully fulfilling a responsibility and coping with a personal challenge (Horowitz, 1982; Reece, Walz, & Hageboeck, 1983). Additionally, caregiving can result in an increasing understanding of the aging relative, putting other stresses into proper perspective, relieving worries that the older relative is being properly cared for, and serving as a role model for one's own children (Danis, 1978; Horowitz, 1985).

In addition to research related to the impact of caregiving, counseling needs of adult children caring for aging parents have been postulated in the literature. These

include needs in the areas of knowledge, emotional support and skill development. More specifically, needs which have been identified in the area of knowledge include a need for accurate knowledge of the aging process and knowledge of available community resources (Clark & Rakowski, 1983; McMahon & Ames, 1983; Miller, 1982; Myers, 1988, 1989; Remnet, 1987; Smith, 1989). Needs identified in the area of emotional support include emotional catharsis, normalization and diffusion of feelings, and the need for reassurance (Altschuler, Jacobs, & Shiode, 1984; Clark & Rakowski, 1983; Cutler, 1985; Dobson & Dobson, 1985; Myers, 1989; Wasow, 1986). Needs related to skill development include increased skills in communication, stress reduction and coping resources (Johnson & Spence, 1982; McMahon & Ames, 1983; Miller, 1982; Myers, 1988, 1989; Remnet, 1987; Smith, 1989).

Outcome measures correlated with these variables (knowledge, emotional support and skill development) have been proposed in the literature. Knowledge may be measured directly in terms of content and comprehension (Johnson & Spence, 1982). Emotional support has been correlated with perceived level of burden in several studies (Novak & Guest, 1989; Zarit, 1982; Zarit, Todd, & Zarit, 1986). Skill development in the areas of stress reduction and coping resources may be measured as perceived level of stress and perceived coping resources (Smith, 1989; Wedl, 1986).

In summary, midlife adult children who are caregivers to aging parents face many difficult challenges. They must struggle with the issues of midlife and filial maturity as well as with the consequences of caregiving. More specifically, midlife adult children who are caregivers to aging parents have been found to have needs in three areas: knowledge, emotional support, and skill development. Counselors can assist these individuals by recognizing their unique needs and implementing counseling interventions to assist them in meeting these needs.

Statement of the Problem

Research has documented that the population of older persons, particularly those over age 85, is growing rapidly. This population contains a significant proportion of impaired older persons who require some assistance with activities of daily living to remain in the community. Family members, particularly spouses and midlife children, provide most of the required care for impaired older persons.

Midlife adult children of aging parents must face several challenges. These include midlife developmental issues, development of filial maturity, and stresses associated with the caregiving role. Additionally, research has documented counseling needs of adult children caring for aging parents in the areas of knowledge, emotional support, and skill development. Emotional needs and issues are

consistently documented as the most stressful for caregivers. Although relatively little is known about how to address these needs, the negative impact of caregiving stress is well documented. Counselors can play an important role in helping to reduce the negative impact of caregiving stresses. Since counselors address stress and other emotional issues from a developmental perspective, we are uniquely suited to provide counseling interventions which will meet the needs of midlife adult children caring for aging parents (Miller, 1982; Myers, 1988, 1989).

Despite the identification of counseling needs and correlated outcome measures, little has been done to develop testable intervention strategies based on these needs for midlife adult children of aging parents. More specifically, counselors could develop and implement testable intervention strategies designed to address the needs of midlife adult children of aging parents. Therefore, the present study was undertaken to develop an intervention which counselors could utilize to address the needs of midlife adult children caring for aging parents. Additionally, the effectiveness of this intervention was evaluated using an experimental research design.

Purpose of the Study

The purpose of this study was to develop, implement and evaluate a group counseling intervention which addressed the counseling needs of midlife adult children caring for aging

parents. This intervention focused on the needs of midlife adult children caring for aging parents in three areas: knowledge, emotional support and skill development.

Research Hypotheses

This study was concerned with developing an intervention to address counseling needs of midlife adult children caring for aging parents. The specific research hypotheses tested were as follow:

1. There is no difference in knowledge of the aging process for treatment and delayed treatment groups across the three occasions following group participation as measured by the Facts on Aging Quiz - Revised.

Hypotheses 2 through 7 relate to emotional support and were measured by the subscales of the Caregiver Burden Inventory (CBI).

2. There is no difference in perceived level of burden due to restrictions on the caregiver's time for treatment and delayed treatment groups across the three occasions following group participation.
3. There is no difference in perceived level of developmental burden for treatment and delayed treatment groups across the three occasions following group participation.
4. There is no difference in perceived level of physical burden for treatment and delayed treatment groups

across the three occasions following group participation.

5. There is no difference in perceived level of social burden for treatment and delayed treatment groups across the three occasions following group participation.
6. There is no difference in perceived level of emotional burden for treatment and delayed treatment groups across the three occasions following group participation.
7. There is no difference in overall perception of caregiver burden for treatment and delayed treatment groups across the three occasions following group participation.

Hypotheses 8 through 13 relate to skill development and were measured by the subscales of the Coping Resources Inventory for Stress (CRIS).

8. There is no difference in stress monitoring for treatment and delayed treatment groups across the three occasions following group participation.
9. There is no difference in self-disclosure for treatment and delayed treatment groups across the three occasions following group participation.
10. There is no difference in the caregiver's ability to organize and manage resources for treatment and delayed treatment groups across the three occasions

following group participation.

11. There is no difference in tension reduction for treatment and delayed treatment groups across the three occasions following group participation.
12. There is no difference in confidence for treatment and delayed treatment groups across the three occasions following group participation.
13. There is no difference in overall perception of coping resources for treatment and delayed treatment groups across the three occasions following group participation.

Definition of Terms

The following terms are used throughout this study:

Dependent aging parents are persons who are over 60 years of age and have at least one child who provides care for them.

Caregiving midlife adult children are persons who are over age 40 and caring for at least one parent who is 60 or more years of age.

Filial maturity is the capacity to accept aging parents and to fulfill their need for help and support (McMahon & Ames, 1983).

Caregiving is defined by the meaning or purpose a caregiver attributes to a behavior rather than by the nature or demands of the behavior itself. Any process engaged in for the purpose of caregiving is therefore included (Bowers, 1987).

Coping is the process through which persons manage the relationship between themselves and their environment when they perceive that relationship as taxing or exceeding their resources and endangering their well-being (Lazarus & Folkman, 1984).

Coping resources are any resources an individual has which may help him or her to cope with stressors. Coping resources include coping skills and also resources which are not skills, such as the presence of a social support network (Pugh, 1984).

Psychoeducational refers to the approach employed in this study in which material is presented in an educational format to the group in general without allowing time for group process to occur.

Group counseling intervention refers to a group approach which employs the use of group interaction to facilitate self-understanding as well as individual behavior change. Mutual support and solutions are suggested and each individual is encouraged to share and work on individual problems (George & Dustin, 1988).

Organization of the Study

The remainder of the study is in four chapters. In Chapter II, the related literature is reviewed and analyzed. This is followed by a discussion of the methodology in Chapter III, which includes a description of the population and sample, sampling procedures, instruments, data

collection, scoring procedures and data analysis. In Chapter IV, the results of the study are presented. Finally, Chapter V includes limitations of the study, a discussion of the results, and recommendations for further research.

CHAPTER II REVIEW OF THE LITERATURE

In Chapter II, a summary and analysis of the professional literature involving midlife adult children caring for aging parents is undertaken. The chapter is divided into seven sections: (a) aging parents, (b) adults in midlife, (c) adult children in midlife, (d) midlife adult children as caregivers, (e) counseling needs of midlife adult children caring for aging parents, (f) measures of knowledge, emotional support, and skill development, and (g) intervention strategies for caregivers. The chapter concludes with a summary of the literature review.

Aging Parents

As discussed in Chapter I, demographic changes are having a profound impact on American society. These changes include dramatic increases in the number and proportion of older persons, particularly those aged 85 and over (Special Committee on Aging, 1983). Many older persons need some type of assistance to remain as independent as possible in the community (Brody, 1974). Family members, particularly spouses and adult children, provide most of this assistance (Cantor, 1983). Therefore, before discussing the needs of caregivers, it is important to understand the needs of the older persons whom they serve. In order to understand the

needs of older persons, developmental tasks of late life are discussed below.

Developmental Tasks in Late Life

According to Havighurst (1972) a developmental task is a task which arrives at or about a certain period in the life of an individual, successful achievement of which leads to happiness and success with later life tasks, whereas failure leads to unhappiness and disapproval by society and difficulty with later tasks (Havighurst, 1972). Several adult development theorists have discussed tasks of late life. These theories are discussed below as they relate to late life tasks.

According to Jung (1933), old age is the final stage of life. This stage is quite similar to childhood. He believed older persons are submerged in the unconscious and gradually vanish within it. Conversely, Buehler (1967) viewed late life as a time when previous activities continue while some goals change and new goals emerge. Reassessment and addition of goals is necessary to meet the changing needs of the individual in areas such as health and work. Specific tasks of late life include need satisfaction, adaptive adjustment, creative expansion, establishment of inner order, and self-fulfillment.

Erikson (1963) saw the major psychosocial crisis of late adulthood as achieving a sense of ego integrity. Ego integrity is achieved by those who feel they have lived a

productive and worthwhile life, coping with successes as well as failures and having few regrets. These persons do not fixate on what they might have done but rather derive satisfaction from what they have done. They are also able to accept their own mortality. Failure to achieve ego integrity may result in feelings of despair, hopelessness, and guilt. Persons who fail to achieve ego integrity focus on what could have been and do not find satisfaction in the lives they have lived. This realization, that they have wasted their lives, results in a sense of despair.

Peck (1968) extended Erikson's theory by further defining tasks of late life. The developmental tasks of late life according to Peck include three normative crises: ego differentiation versus work role preoccupation, body transcendence versus body preoccupation, and ego transcendence versus ego preoccupation. Ego differentiation involves redefining oneself as a worthwhile person outside the work role. This usually occurs with retirement when an individual must shift from values related specifically to the work role to values related to a broad range of role activities. The second task, body transcendence versus body preoccupation, involves a recognition and acceptance of physical declines while at the same time increasingly valuing social and mental sources of pleasure and self-respect. Achievement of body transcendence allows the individual to overcome physical decline and discomfort by

redefining pleasure and self-satisfaction in terms of mental and social activities. The final task, ego transcendence versus ego preoccupation, involves acceptance of one's own mortality and working toward actions which go beyond the limit of one's own life to leave something of value for the next generation.

Late life tasks have also been defined by Havighurst (1972). According to Havighurst (1972), several limitations become evident during late life that affect the tasks of this period. These limitations include the increased probability that income will be reduced, physical problems will develop, death of a spouse may occur, and a change in residence may be necessary. These events require older persons to make adaptations and learn new ways of living. Havighurst has therefore postulated six developmental tasks of later adulthood: (a) adjusting to decreased physical strength and health, (b) adjusting to retirement and reduced income, (c) adjusting to death of a spouse, (d) establishing an explicit affiliation with one's age group, (e) meeting social and civic obligations, and (f) establishing satisfactory physical living arrangements.

Late life according to Gould (1978) is a time of growing tolerance. Persons in this stage must work on accepting the past. This is accompanied by a general mellowing and less negativism. This stage is further characterized by a growing inner-directedness.

Although Neugarten (1968) did not specify developmental stages, she reported several research findings which are relevant to the discussion of late life tasks. Like Gould, she argued people become more inner-directed in late life. Furthermore, she stated people become more like themselves as they age. That is, as lives grow longer and individuals accumulate more experiences, lives begin to differentiate from one another. Additionally, Neugarten stressed generational differences based on perceptions of time. She describes three kinds of time: historical time, life time, and social time. Historical time is defined as calendar time which impacts individuals by prescribing age-appropriate behavior. Life time is defined as chronological age and encompasses biological changes. Social time is defined as the social norms and expectations prescribed by society for individuals at different ages. This concept of time is particularly important because it impacts individuals' perceptions of the proper ordering of major life events. For example, society dictates individuals should take jobs, marry, have children and retire in a specific order. If this order is not followed, individuals must suffer the consequences of being "off-time," which include feelings of anxiety, uncertainty, and inadequacy.

In summary, developmental theorists have defined several tasks related to late life. These include establishing a sense of inner order and self-satisfaction,

adjusting to age-related changes, and dealing with multiple losses. Counselors must be familiar with developmental tasks of late life as well as the needs of aging parents in order to effectively work with older persons and their families. The needs of aging parents are discussed in the following section.

Needs of Aging Parents

Primary needs of aging parents have been identified in the literature in several areas including financial, physical, and psychosocial needs. Although older persons have the same needs as persons of any age, there is a substantial difference in degree (Carroll, 1978; Myers, 1984). Myers (1984) points out that as the needs of older persons increase, their financial, personal, and interpersonal resources decrease. Therefore, many older persons require some type of assistance in order to meet their needs. Needs of older persons and correlates of life satisfaction identified in the literature are discussed below.

Twenty psychosocial needs of older persons have been identified by Carroll (1978). These include the need for dignity, safety, privacy, independence, security, control, territoriality, intimacy, touch, being needed, orientation, belonging, sexuality, communication, leaving a legacy, impacting the environment, choice, meaningful roles, health care, and stimulation. Furthermore, she suggested

interventions which may assist older persons in meeting these needs. Some examples of interventions include adapting the environment to compensate for physical problems to meet the needs of independence; assisting older persons in keeping physically fit and maintaining a positive outlook to meet health care needs; and providing assistance with ambulation, bathing, sitting, and standing to meet safety needs.

Brubaker (1987) suggests older persons have needs in three areas: financial, physical, and socio-emotional. These needs are interrelated and one may confound another. Financial needs are often a result of the necessity to live on a reduced, fixed income following retirement. Physical needs include assistance with transportation due to decreased mobility, physical therapy, medication regimens, and other specialized medical treatment. The socio-emotional area encompasses needs related to interaction, belonging, and social contact.

An alternative typology for classifying needs of older persons was proposed by Horowitz (1985). This typology discusses needs of older persons in four areas: emotional support needs, direct service provision needs, mediation with formal organization and provider needs, and financial needs. Needs within the area of emotional support include maintenance of interaction, social contact, and morale. Direct service provision needs include the areas of

transportation, personal care, homemaking, health care, and supervision. Mediation with organizations includes needs associated with linking, mediating, and managing community services. Financial needs are those needs associated with living on a fixed income.

According to several researchers (e.g., Butler & Lewis, 1982; Carroll, 1978; Jacobsen, 1988; Kermis, 1984; Silverstone & Hyman, 1982) , a primary need of older persons is to maintain their independence. Life satisfaction, a generalized feeling of well-being, correlates highly with independence and "successful aging" (Lohman, 1977; Neugarten, Havighurst, & Tobin, 1968). Problem solving, social support, confidence, and flexibility have also been found to be positively correlated with life satisfaction among older persons (Wedl, 1986). Additionally, one of the most consistent predictors of life satisfaction has been health (Ward, 1984).

Once developmental needs of late life and needs of older persons have been defined, the question arises: How do older persons meet these needs at a time when their resources are declining and their needs are increasing? According to the literature related to caregiving and older persons, the family has been identified as the major source of assistance to older persons (Brody et al., 1979; Kaufman, 1980; Shanas, 1979; Silverman, Kahn, & Anderson, 1977; Troll, 1971; Troll, Miller, & Atchley, 1979). The following

discussion addresses the role of families in meeting the needs of older persons.

Meeting the Needs of Older Persons

Families provide 80% of all home health care for older persons (National Center for Health Statistics, 1978). Conversely, 80 percent of all older people with home health care needs depend primarily on their families (Gurland, Dean, Gurland, & Cook, 1978). Shanas (1979b) has estimated that for every one older resident in a nursing home, there are two in the community with similar needs being cared for by families. Furthermore, widowhood, living alone, and childlessness have consistently emerged as significant predictors of nursing home placement (Johnson & Catalano, 1981; Wan & Weissert, 1981). Based on these research findings, it is clear that families assist older persons by helping them maintain independence, health status, and life satisfaction through the provision of caregiving services.

As discussed in Chapter I, although the literature refers to "the family caregiving system," researchers have consistently confirmed that one family member occupies the role of primary caregiver (Horowitz, 1985). Additionally, the identity of the primary caregiver follows a hierarchical pattern. This pattern begins with the spouse, if there is one available and capable, and a child if there is not (Arling & McAuley, 1983; Cantor, 1983; Johnson, 1983; Johnson & Catalano, 1981; Keith, 1983; Kivett & Learner,

1980; Shanas, 1979a, 1979b; Stroller, 1982; Stroller & Earl, 1983; Tobin & Kulys, 1981). Additionally, studies report that females predominate over males as caregivers in all situations (Brody, 1981; Cantor, 1983; Johnson, 1983; Stroller, 1982; Troll, 1971; Troll et al., 1979).

The demography of the family structure and gender differences in life expectancy indicate that the usual caregiver for the older man is his elderly wife and for an older woman, her adult middle-aged child (predominately a daughter). Because women over age 85 outnumber men by a ratio of approximately 2:1 (Butler & Lewis, 1982), it becomes clear adult children provide a very significant proportion of caregiving to women in particular. Because caregiving may occupy a large amount of the caregiver's time and may produce significant levels of stress (Horowitz, 1985), it is important to examine the impact of providing care on adult children. A discussion of adults in midlife can contribute to an understanding of the impact of caregiving on adult children and is undertaken in the following section.

Adults in Midlife

For the purposes of this review, adults in midlife have been defined as those adults who are between the ages of forty and seventy years of age. This group has been referred to as the "command generation" because they occupy positions of power and authority (Neugarten, 1968). They

have also been called the "sandwich generation" because their needs are caught between the needs of their adolescent children and the needs of their aging parents (Miller, 1981). Developmental tasks associated with midlife, briefly presented in Chapter I, will be reviewed indepth in this section and their implications for adults in midlife discussed.

Theoretical perspectives of adult development may be placed along a continuum according to the degree of predictability or variability in the life course emphasized in each theory (Schlossberg, 1984). According to Schlossberg (1984), there are three important orientations along this continuum: age and stage theories, life events and transition theories, and individual timing theories. These orientations will be utilized to discuss adult development theories related to mid-life.

Age and Stage Theories

Age and stage theories emphasize the predictability of the life course. These theories assume individuals pass through similar experiences at similar ages. A number of theorists Havighurst (1948), Erikson (1963), Peck (1968), Levinson (1977), Gould (1978), Jung (1933), and Buehler (1967) address adults in midlife and their theories will be discussed below.

As stated in Chapter I, Havighurst (1948) defines a developmental task as a task which arrives at or about a

certain period in the life of an individual, successful achievement of which leads to happiness and to success with later life tasks, whereas failure leads to unhappiness and disapproval by society, and difficulty with later tasks. According to Havighurst, middle adulthood is a time of peak productivity for individuals when they exert their greatest influence on society. It is also a time when society places the greatest demands on individuals. He proposed six tasks of midlife: (a) achieving adult civic and societal responsibility; (b) establishing and maintaining an economic standard of living; (c) assisting teenage children to become responsible adults; (d) developing adult leisure activities; (e) relating oneself to one's spouse as a person; and, (f) accepting the physiological changes of middle age.

Erikson (1963) proposed eight stages of human development each with a central psychosocial crisis. The central theme for middle adulthood is generativity versus stagnation. Generativity refers to the course a person pursues in providing for offspring and to the person's concern for assisting and guiding the next generation. Successful resolution of this stage involves developing a feeling of having left something of value to future generations. Failure to resolve this task results in a sense of personal impoverishment or stagnation.

Peck (1968) has extended Erikson's theory by further defining tasks of middle adulthood. The developmental tasks of midlife according to Peck include four normative crises: valuing wisdom versus valuing physical powers, socializing versus sexualizing, cathectic flexibility versus cathectic impoverishment, and mental flexibility versus mental rigidity. The first crisis involves a shift in values, related to physical decline beginning in midlife, from emphasis on physical performance to emphasis on mental performance. The second crisis involves relating to persons of the opposite sex as individual personalities rather than primarily sex-objects, resulting in a richer interpersonal life. The third crisis involves developing emotional flexibility, the capacity to shift emotional investments from one person or activity to another. This is important in midlife because of the increased possibility that one's children begin to leave home, and parents and relatives may die. The fourth crisis related to midlife involves keeping an "open mind." That is, staying open to new ideas and new ways of coping versus remaining rigid and unable to accept change.

Levinson (1977) and his colleagues spent ten years studying a sample of 40 men. From this work, they postulated a psychosocial theory of development for men that included five stages related to midlife. These include settling down, midlife transition, entering middle

adulthood, age 50 transition, and culmination of middle adulthood. However, the main focus of his research was related to the mid-life transition. Levinson suggested that men, from ages 33 to 40, experience a period of settling down into adult life. This period is characterized by tasks such as establishing a niche in society and planning and building a good life, attaining major goals, and making a contribution to society. This period is followed by the mid-life transition which occurs between the ages of 40-45 and is characterized by a period of questioning and taking stock of one's life. The period of middle adulthood is characterized by making choices, based on the questioning of the previous period, to form a new life structure and committing to these new choices. The age 50 transition encompasses further questioning and modification of life structures. Finally, the culmination of middle adulthood involves building a new life structure and can be a time of great fulfillment.

Gould (1978) proposed a developmental theory based on seven stages. Midlife tasks according to this theory are related to a sense of urgency to attain life's goals. This is precipitated by an awareness of time limitation and result in the realignment of life goals. Three of Gould's stages are related to this discussion of midlife. The first stage involves questioning life's meaning. The second stage includes continued questioning of values, a recognition that

time is finite, and a developing awareness of responsibility for one's parents as well as one's children. The third stage results in a recognition that one's occupational die is cast. Also, an interest in friends increases as does reliance on one's spouse.

Jung (1933) states that the main task of middle age is to recenter one's life around a new set of values. Energy previously used to deal with external problems is now refocused internally to develop a new set of spiritual values. He further views middle age as a time to prepare for old age and death.

One of the tasks of midlife according to Buehler (1967) is to realize that life is finite which may, in turn, prompt a period of self assessment. During this period, individuals evaluate successes and failures to establish an inner order. It is during this phase that individuals may choose to modify their lives.

Life Events and Transition Theories

Life events and transition theorists emphasize the impact of change on the life course. The focus of these theories is on life events and transitions (i.e. divorce, marriage, retirement, etc.) and related stresses rather than on chronological age to understand development. Lowenthal, Thurnher, and Chiriboga (1975) took a life stage orientation in their study entitled "Four Stages of Life." This longitudinal study involved graduating high school seniors,

newlyweds, middle-aged parents, and pre-retirement couples in the San Francisco area. Each of these groups were facing a major transition at the beginning of the study. At the completion of this study, the researchers concluded that these groups differed significantly in their general outlooks on life and the stresses they faced. Furthermore, the researchers concluded it was more valuable to know the transitions or life events an individual was facing than it was to know the individual's chronological age when attempting to understand and evaluate behavior.

Other researchers who employ a life events and transition approach include Baltes and Danish (1980), Brim and Ryff (1980), Dohrenwend, Krasnoff, Askenasy, and Dohrenwend (1978), Pearlin (1980), and Schlossberg (1984). These theorists have emphasized the role of life events and transitions as giving shape and direction to various aspects of an individual's life. Furthermore, stresses and coping strategies associated with transitions are studied to understand the impact of transitions on the individual.

Although no specific tasks of midlife are associated with these theories, they are relevant to the discussion of midlife. Most researchers agree midlife is a time of great change. Many transitions are associated with this lifestage, such as divorce, remarriage, empty nest, beginning a new career, and retirement. Therefore, life stage and transition theories are particularly important to

consider when counseling adults in midlife because they focus on changes and the impact these changes have on individuals.

Individual Timing and Variability Theories

Individual timing and variability theorists focus on the increasing variability among individuals as they age. Theorists who subscribe to this orientation include Neugarten (1968), Vaillant (1977), and Pearlin and Leiberma (1979).

Neugarten (1968) refers to midlife as a time of reflection, stocktaking, and heightened introspection. It is a period when an individual's time perspective changes from "time since birth" to "time left to live." Furthermore, Neugarten refers to the concept of "individual fanning out" over the lifespan. That is, as individuals age and as successive choices and commitments accumulate, lives grow different from each other.

The work of Vaillant (1977) further supports the variability concept. Referring to the outcomes of the Grant Study, he states that "the life cycle is more than an invariant sequence of stages with single predictable outcomes" (1977, p. 373). He also states that "it is not the isolated traumas of childhood that shape our future, but the quality of sustained relationships with other people" (Vaillant, 1977, p. 29).

Pearlin and Leiberman (1979) document variability throughout the lifespan through their work involving life strains. They found that life strains are differentially distributed according to age, sex, and socioeconomic status. This finding is important to the discussion of theories of midlife because most adult development theories to date are based on data which describe middle-class adults, particularly middle-class males. Therefore, it is important for counselors working with adults in midlife to be aware that issues identified in adult development theories may not apply equally for all individuals in midlife, especially women, minorities, and members of the lower and upper social classes.

Summary of Developmental Issues in Midlife

In summary, midlife is a time of taking stock of one's life. This is precipitated by a change in time perspective from time since birth to time left to live and an accompanying sense of urgency. Midlife is also a time when adults experience the greatest sense of power and, at the same time, have the greatest number of societal demands placed upon them. As a result, adults in this stage are working to balance career, family and civic responsibilities while undertaking an examination of their lifelong goals. Identity and intimacy issues may resurface during this period. Additionally, adults in midlife may experience transitions, either anticipated or unanticipated, such as

divorce, re-entry into the work force, and caring for aging parents. Mid-life adult children of aging parents must face issues related to midlife while struggling with the issue of filial maturity as well. The concept of filial maturity and issues related to adult children of aging parents are discussed below.

Adult Children in Midlife

As discussed in Chapter I, filial maturity refers to the capacity to accept one's aging parents and to fulfill their needs for help and support. The issue of filial maturity usually occurs in middle age. It is during this time that middle age children begin to truly appreciate their parents and see the relevance of their parents' lives to their own (Blenkner, 1965, Troll et al., 1979). Although the development of filial maturity is important for both middle age children and their aging parents, there are several issues which make attainment of this goal difficult.

First, parent-child relationships are often adversely affected by prevalent negative stereotypes related to aging (Myers, 1988). The myth of abandonment, discussed above in the historical overview, continues to be pervasive in American society (Shanas, 1979a). Other common, inaccurate stereotypes related to aging include the misconception that most older persons are institutionalized; that they will move in with their adult children if they are not institutionalized; and that all older persons are alike,

sick, poor, depressed, and a drag on everyone else (Kermis, 1984; Myers, 1988, 1989).

Secondly, adult children faced with the issue of aging parents must realize that their parents, who were viewed in childhood as a source of strength and support, are vulnerable and mortal (Myers, 1988). As the dependency needs of the parents increase, this becomes more evident. Furthermore, the recognition that one's parents are aging precipitates the recognition of one's own aging. Therefore, adult children must not only deal with the issue of aging in relation to their parents but also in relation to themselves (Brammer, Nolen, & Pratt, 1982).

Thirdly, adult children struggling to achieve filial maturity lack appropriate role models for relating to aging parents. Often, both adult children and their aging parents fail to realize that traditional roles must be altered (Dobson & Dobson, 1985). Role reversals and, more commonly, role strains are experienced by both adult children and their aging parents (Myers, 1988). Additionally, unresolved conflicts between adult children and their aging parents may be reactivated as the dependency needs of the parents increase (Myers, 1989).

Adult children in midlife must face developmental tasks related to midlife while struggling to achieve filial maturity. Although the transitions of midlife include the potential for independence, self-direction, and the pursuit

of goals postponed during the child-rearing years, these new-found freedoms may be halted as the needs of aging parents increase. This may precipitate feelings of resentment, anger and guilt for midlife adult children (Myers, 1989). Additionally, adult children in midlife whose parents become increasingly impaired and dependent are faced with stresses related to the role of caregiving, discussed below.

Midlife Adult Children as Caregivers

For the purposes of this study, caregiving is defined by the meaning or purpose a caregiver attributes to a behavior rather than by the nature or demands of the behavior itself. Any process engaged in for the purpose of caregiving is therefore included (Bowers, 1987). Horowitz (1982) conceptualized caregiving behavior as falling into four broad categories: emotional support, direct service provision, mediation with formal organizations and providers, and financial assistance. This framework will be used in the following discussion of caregiving activities.

Emotional Support

The task of emotional support includes maintaining social interaction and "cheering up" when depressed. Many investigators do not include emotional support as a separate component of the caregiving process because it is often considered to be part of normal family interactions (Horowitz, 1985). However, when emotional support is

included as a separate task of caregiving, it emerges as the most universal caregiving task (Lang & Brody, 1983; Sherman, Horowitz, & Durmaskin, 1982). Cicirelli (1983) found that providing emotional support, regardless of the extent of caregiving, was defined by the caregiver as the most important type of assistance provided to the older person.

Direct Service Provision

Direct service provision is the broadest category of service provision and encompasses activities such as shopping, errands, transportation, housekeeping, meal preparation, personal care (e.g. dressing, bathing, etc.), financial support, and health care. Danis (1978) found that most caregivers provided transportation for doctor visits, ran frequent errands, and maintained daily telephone contact. Additionally, Reece et al. (1983) found that shopping and transportation were the most commonly provided services, but almost half of the caregivers studied also provided personal care services.

Mediation with Organizations

According to Shanas and Sussman (1977), family caregivers can act as a buffer between organizations and older persons by examining the services provided by the organizations, effecting entry of the older person into the service, and facilitating the continuity of the relationship between the older person and the service. However, in a later article, Shanas and Sussman (1981) noted that although

it is assumed that the family is more knowledgeable regarding services provided for older persons by formal organizations; in fact, both older persons and family members may be ignorant of the structure of bureaucracies. Furthermore, according to Brody (1979), the aging phase may represent the first time any member of the family has had the need to use formal services. Overall, mediation with organizations, like emotional support, appears to be assumed rather than studied as a separate component of caregiving (Horowitz, 1985).

Financial Assistance

In every survey of older persons and their families, the socio-emotional aspects of caregiving are rated as more important than financial assistance (Callahan et al., 1980). Older persons do not expect their children to provide financial support and their children concur, consistently placing the responsibility for financial support upon government agencies (Cantor, 1980; Harris & Associates, 1975). However, although governmental entitlement programs provide financial assistance for basic needs, many children provide some form of regular financial support for "necessary extras" such as extra clothing or additional groceries (Cantor, 1980; Horowitz, 1985).

The provision of care as described above impacts the family unit. A review of the literature related to caregiving indicates that there are both benefits and costs

associated with the provision of care (Horowitz, 1985).

Benefits and costs of caregiving are discussed below.

Benefits of Caregiving

Although the benefits of caregiving have been largely neglected in the literature, the researchers have suggested that caregivers can identify at least one positive aspect associated with providing care when asked directly (Horowitz, 1982; Reece, Walz, & Hageboeck, 1983). Positive aspects associated with the provision of care include generating feelings of self-satisfaction and self-respect, developing an increased understanding of the aging relative, putting other stresses into perspective, decreasing worries that the older relative is being properly cared for, and serving as a role model for one's own children (Danis, 1978; Horowitz, 1985).

Costs of Caregiving

The demands and costs associated with caregiving have been extensively documented in the literature. Negative consequences of caregiving have been identified in several areas including financial, physical, social, and emotional stresses. As stated in Chapter I, it is important to note that not all caregivers will experience all of these problems nor will every problem be experienced to the same degree by all caregivers. In fact, although most investigators have reported that substantial numbers of caregivers undergo moderate to extreme stress, they also

noted that, given the severity of the care receivers problems and the demands of the caregiving role, the overall level of burden, disruption, or stress is less than would be expected (Cicirelli, 1981; Zarit, Reeve, & Bach-Peterson, 1980). In general, families have been found to demonstrate remarkable adaptive capabilities in response to the financial, physical, social, and emotional stresses related to caregiving (Horowitz, 1985).

Financial Stresses

There is widespread evidence that although caregiving may involve financial contributions which may strain the economic resources of the family, caregivers report that financial demands are the easiest to deal with when compared to the social and emotional stresses associated with caregiving (Arling & McAuley, 1983; Cantor, 1983; Frankfather et al., 1981; Horowitz, 1982). Spouses are more likely to report financial hardship than other caregiving relatives. However, they also report that financial concerns are less stressful than other aspects of caregiving (Cantor, 1983; Horowitz, 1985).

Financial hardships associated with the caregiving role may be experienced indirectly by adult children caring for aging parents. There is increasing evidence that the impact of caregiving on ability to work is substantial for significant numbers of caregivers (Horowitz, 1985). According to Soldo and Myllyluoma (1983), caregiving does

deter labor force participation, particularly among older women. Stone, Cafferata, and Sangl (1987) found that 12% of the daughters and 11% of the sons in their national sample of caregivers reported leaving the work force to care for an aging parent. This is consistent with the findings of a previous study by Brody et al. (1983) in which the majority of the respondents expected working daughters rather than sons to quit their jobs or to rearrange their work schedules for parent care.

Cantor (1980) reported that many caregivers had to forego job opportunities or reduce their work schedules. Additionally, researchers have documented that caregivers report their performance at work has suffered (Archold, 1983; Horowitz, 1982). Stone et al. (1987) found that 20% of all caregivers reported conflicts between work and caregiving resulting in alteration of their work schedules. Among the one million caregivers who had been employed during some part of the caregiving experience, 20% reduced the number of hours worked, 29% rearranged their schedules, and 19% took time off without pay to fulfill caregiver obligations. However, studies of the degree to which employment impinges on caregiving have produced equivocal results (Stone et al., 1987).

Physical Stresses

The emotional and physical drains of caregiving have been found to negatively effect caregiver health (Horowitz,

1985). Negative effects on the caregiver's health are particularly evident when the caregiver is experiencing his or her own aging and when caregiving involves physical tasks such as bathing (Archold, 1980; Frankfather et al., 1981).

In a study of psychological and health consequences of caregiving, Haley, Levine, Brown, Berry, and Hughes (1987) found caregivers reported poorer health than individuals in the control group. Furthermore, caregivers reported seeking more medical care than controls. Caregivers also reported using more prescription medications than individuals in the control group and several caregivers reported experiencing major health problems.

Social Stresses

Negative consequences of caregiving in this area include neglect of familial responsibilities, family conflict, and a lack of time to engage in social activities outside one's family. Spending time away from one's family and neglecting family responsibilities are problems frequently reported by caregivers (Archold, 1983; Arling & McAuley, 1983; Horowitz, 1982). Furthermore, other studies have found that caregivers often report increased family conflicts and disrupted family relations stemming from the caregiving role (Rabins et al., 1982; Stone et al., 1987).

Several researchers report that another negative consequence of caregiving is a strained affective relationship between the caregiving relative and the

dependent older person (Archold, 1983; Cantor, 1983; Frankfather et al., 1981). However, Horowitz (1985) argued that although conflicting needs and stresses inherent in a caregiving situation may affect the ability to get along on a daily basis, the overall relationship and feelings between the caregiving relative and the dependent older person may remain unchanged. Additionally, Cantor (1983) reported that among children the normal strains of caring for an ill parent seemed to be compounded by intergenerational differences. Only 48% of the children felt that they understood their sick parent well, and only 28% felt they were understood in return.

Caregivers also report restricted social activities outside the family (Horowitz, 1985; Cantor, 1983). Although the size of the actual social network of caregivers and non-caregivers is similar, caregivers are significantly less satisfied with their networks. More specifically, caregivers report less time for activities with friends, current and planned vacations, and church attendance (Cantor, 1983; Haley et al., 1987).

Emotional Stresses

As discussed in Chapter I, emotional stresses are consistently reported as the most pervasive and most difficult for the caregiver to deal with compared to either the physical or financial aspects of care (Cantor, 1983; Cicirelli, 1980; Haley et al., 1987). For many caregivers,

emotional strains occur as a result of constant concern for the health and safety of the older person as well as the need to redefine and come to terms with the changing nature of their relationship with the older person (Horowitz, 1985). For adult children, the emotional stresses related to caregiving often involve coping with the "filial crisis," that is, realizing and accepting that the aging parent is no longer the "pillar of strength" from the past (Blenkner, 1965). The struggle for filial maturity involves an acceptance of responsibility and an acceptance of what can be done and what cannot be done for the aging parent. It is this struggle to define "what is enough" which often precipitates feelings of guilt and increases emotional stress (Blenkner, 1965; Horowitz, 1985).

Additionally, restrictions on time and freedom dictated by caregiving responsibilities contribute to the emotional stresses experienced by caregivers. Caregiving activities often involve an extensive readjustment in daily schedules for the caregiver. Disruption of domestic routines, decreased personal time, less time for social and leisure activities, inability to take vacations, rearrangement of work schedules, and restricted mobility further contribute to the emotional strains of caregiving (Archold, 1980, 1983; Arling & McCauley, 1983; Cantor, 1983; Horowitz, 1982; Rabins et al., 1982). Furthermore, a significant proportion of caregivers report increased levels of depression and

anxiety as well as decreased levels of morale and life satisfaction (Gurland et al., 1978; Haley et al., 1987; Rabins et al., 1982).

In summary, a substantial proportion of caregivers are faced with financial, physical, social and emotional strains related to caregiving. Additionally, many midlife adult children caring for aging parents are juggling familial and employment responsibilities which place competing demands upon them. Counselors can assist midlife adult children by recognizing their special needs and formulating interventions to assist them in meeting the challenges of caring for their aging parents. These challenges contribute to the counseling needs of midlife adult children caring for aging parents, which are discussed below.

Counseling Needs of Midlife Children Caring for Aging Parents

Counseling needs of midlife adult children caring for aging parents have been postulated in the literature. These needs are based upon developmental tasks of midlife which have been identified in the literature related to adult development (Bleckner, 1965; Havighurst, 1972) and upon stresses related to the caregiving role which have been identified in the literature related to caregiving (Archold, 1983; Cantor, 1983; Haley et al., 1987). Counseling needs of midlife adult children caring for aging parents have been identified in three areas: knowledge, emotional support,

and skill development. Counseling needs in each of these areas are discussed below.

Knowledge

In studies addressing needs of adult children of aging parents, accurate knowledge of the aging process and knowledge of community resources was consistently ranked by participants as the area of greatest need (Clark & Rakowski, 1983; Miller, 1982; Remnet, 1987; Smith, 1989). Knowledge of the aging process includes knowledge of physical and psychological changes associated with aging. Knowledge of available community resources includes knowledge of programs designed to assist older persons with housing, transportation, meals, respite, and adult day care. This area also includes information on nursing home placement and alternatives to nursing home placement (Miller, 1982; Smith, 1989).

Emotional Support

The area of emotional support encompasses needs for emotional catharsis, normalization and diffusion of feelings, and reassurance (Altschuler et al., 1984; Myers, 1989; Wasow, 1986). According to McMahon and Ames (1983), midlife, parent-caring adults need an opportunity to air feelings of frustration, guilt, and conflict evoked by trying to fulfill aging parents' expectations, while struggling to maintain time for the realization of personal expectations. Needs in this area are particularly

significant considering the fact that caregivers consistently rate emotional stresses as the most difficult for them to address (Horowitz, 1985).

Skill Development

Needs related to skill development include increased skills in communication, and increased awareness and implementation of coping resources (Johnson & Spence, 1982; McMahon & Ames, 1983; Miller, 1982; Myers, 1988, 1989; Remnet, 1987; Smith, 1989). Cicirelli (1981) suggested that adult children should become more sensitive to the need for communication with elderly parents. Furthermore, he stated counselors can improve the ability of adult children to help their parents by focusing on increasing communication skills. Improved communication skills may also reduce stresses associated with the caregiving role related to intergenerational differences (Cantor, 1983).

The need for increasing coping resources available to an individual is reflected in the caregiving literature which reports that many caregivers experience high levels of stress and anxiety associated with the caregiving role (Gurland et al., 1978; Haley et al., 1987). Lazarus and Folkman (1984) defined stress as a particular relationship between the individual and the environment that is perceived by the individual as taxing or exceeding his or her coping resources and endangering his or her well-being. Coping resources include any resources an individual employs to

assist him or her in coping with stressors (Pugh, 1984). Examples of coping resources include the use of progressive relaxation, physical exercise, social supports and respite programs to decrease caregiver stress. Counselors can assist caregivers by helping them identify and utilize available coping resources in order to decrease stress and anxiety, and increase life satisfaction.

In summary, counseling needs of midlife adult children caring for aging parents have been proposed in the literature. These needs include the areas of knowledge, emotional support, and skill development. If an intervention is to be developed to meet these needs, it is important that techniques to measure change in each area are available. Measures of knowledge, emotional support, and skill development are discussed below.

Measures of Knowledge, Emotional Support, and Skill Development

Outcome measures correlated with the variables of knowledge, emotional support, and skill development have been proposed in the literature. Knowledge may be measured directly in terms of content and comprehension (Anastasi, 1982; Johnson & Spence, 1982). Emotional support has been correlated with perceived level of burden in several studies (Novak & Guest, 1989; Zarit, 1982; Zarit, Todd, & Zarit, 1986). Skill development in the areas of stress reduction and coping resources may be measured as perceived level of stress and perceived coping resources (Smith, 1989; Wedl,

1986). Specific measures of knowledge, burden, and stress coping resources are discussed below.

Knowledge

As noted above, knowledge may be measured directly in terms of content and comprehension. The focus of this type of testing is on what the individual knows and may be accomplished using a pre-test/post-test methodology. In this type of testing, it is the change in the individual's score which is important and not how he or she compares to others. The fundamental requirement in constructing this type of measure is clearly defining the domain of knowledge to be assessed (Anastasi, 1982).

Once the domain of knowledge has been defined, instructional objectives must be developed. Examples of instructional objectives include "can list three community-based resources for older persons" or "correctly identifies four age-related changes". In this way, an individual's increase in knowledge of a particular content area may be measured by testing knowledge prior to knowledge presentation and following knowledge presentation.

An instrument which has been formulated to measure knowledge of the aging process is the Facts on Aging Quiz (FAQ) developed by Erdman Palmore (1988). This instrument was designed to overcome three main weaknesses of previous tests: long length, confusion of facts with attitudes, and lack of documentation related to test questions. The FAQ is

short (25 items), confined to factual statements, and each item is documented by empirical research. It was designed to cover basic physical, mental, and social facts related to the aging process (Palmore, 1988).

In 1980, Miller and Dodder revised the FAQ in answer to criticisms of the instrument. One of the major revisions was to remove ambiguous terminology. The revised scale replaced the term "most" with the term "majority" which was defined as "more than half." Having been defined in such a manner, the concept "majority" is less open to individual interpretation than when the term "most" was used and the same definition serves as a point of reference consistently throughout the questionnaire.

Another revision made by Miller and Dodder (1980) included modifying six questions which were "double-barreled." These questions were questions which referred to two distinct concepts and therefore, the researcher could not be sure to which one the subject was referring when answering. In an attempt to avoid these "double-barreled" statements, only one key concept was kept in each question. Item 13 was totally omitted due to the difficulty in concluding the "correct" answer from current research which is ambiguous. Item 21 was also modified to replace the statement "defined by Federal Government" with the actual governmental monetary guideline values (Miller & Dodder, 1980).

The revised version of this instrument has been chosen for use in this study because it has been used as a measure of knowledge related to aging and it has improved on the original version. The instrument will be further reviewed in Chapter III.

Emotional Support

A number of unidimensional burden scales have been developed (Morycz, 1985; Robinson, 1983; Zarit et al., 1980; Zarit & Zarit, 1982). These scales focus on the caregivers' feelings and experiences and measure similar facets of burden including health status, financial strain, social activity, and disturbed feelings. Additionally, all of these measures produce total scores representing overall burden (George & Gwyther, 1986).

Due to the fact that these measures produce only a total score representing overall burden, they do not permit distinctions between the dimensions of burden (Novak & Guest, 1989). According to George & Gwyther (1986), relying on summary scores masks dimension-specific patterns of caregiving which impact burden and precludes identification of the different correlates of specific dimensions of caregiver burden. Niederehe and Fruge (1984) recommended that researchers use multidimensional measures of burden that reflect various areas of caregiver well-being and function that may be differentially affected.

Multidimensional measures of caregiver burden have been utilized by several investigators (Montgomery, Gonyea, & Hooyman, 1985; Niederehe, Fruge, & Woods, 1983; Poulshock & Deimling, 1984). However, the generality of subscale concepts (Montgomery et al., 1985), the large number of items (Niederehe et al., 1983), and the small number of subscales (Poulshock & Deimling, 1984) limit the reliability and the applicability of these scales (Novak & Guest, 1989).

Novak and Guest (1989) have developed a multidimensional measure of caregiver burden, the Caregiver Burden Inventory (CBI), which was designed to overcome many of the criticisms of previous measures. The CBI is composed of five subscales which include time-dependence burden, developmental burden, physical burden, social burden, and emotional burden. Each subscale consists of five questions, with the exception of the physical burden scale which contains four questions, resulting in a total of twenty four items. Additionally, the CBI produces good internal consistency coefficients ranging from .85 to .77.

Therefore, the CBI has been chosen for use in the present study because it is a multidimensional measure of caregiver burden, has five distinct subscales, is relatively short and produces good internal consistency coefficients.

Skill Development

Coping may be defined as the process by which persons manage the relationship between themselves and their

environment that they perceive as taxing or exceeding their resources and endangering their well-being (Lazarus & Folkman, 1984). Coping resources have previously been defined as any resources individuals possess which may help them cope with stressors including both coping skills and resources which are not skills, such as the presence of social supports (Pugh, 1984). Although much research has been done in the area of coping resources, only a few instruments for assessing coping resources have been developed. This lack of assessment instruments has been largely due to differing definitions of coping (Wedl, 1986).

Traditional models of coping have emphasized traits or styles, that, once established, tend to operate as stable dispositions throughout the individual's life (Lazarus & Folkman, 1984). According to Lazarus & Folkman (1984), the assessment of coping resources employing the above definition has limited value. These authors stated that "one-shot" measures of coping have been inadequate in assessing adaptation or in predicting how individuals will react over time or across situations.

Based upon their research on coping, Lazarus & Folkman (1984) developed the Ways of Coping checklist. Items on this instrument differentiate between the broad functions of emotion-focused and problem-focused coping. Problem-focused factors include cognitive and behavioral problem solving strategies such as information seeking and strategy

formulation. Emotion- focused factors include such strategies as seeking emotional and social support, avoiding, distancing, and self-blaming (Lazarus & Folkman, p. 319). Additionally, The Ways of Coping checklist measures four basic modes of coping: direct action, inhibition of action, information search, and cognitive coping.

The Coping Strategies Inventory (CSI) developed by Tobin, Holroyd, & Reynolds (1984) is also designed to measure stress coping resources. This instrument is an adaptation of the Ways of Coping checklist. It is a 72-item self-report questionnaire designed to assess coping thoughts and behaviors in response to a specific stressor. Individuals are first asked to describe the events and circumstances of a stressful situation in a paragraph or two. Following this, individuals are asked to complete the CSI, a 5-item Likert-format questionnaire.

Another instrument developed to measure coping resources is The Coping Resources Inventory for Stress (CRIS) developed by Matheny, Currette, Aycock, Pugh, & Taylor (1984). This inventory measures the individual's perceived capacity to cope with stress and provides a measure of the intervening variable between the stressor and the effects of stress. The CRIS includes a measure of eleven theoretical constructs: stress monitoring, self-disclosure, structuring, social support, tension reduction,

flexibility, confidence, acceptability, physical fitness, wellness, and problem solving. The inclusion of these constructs is particularly important because they allow for accurate formulation of treatment modalities. Most, if not all, of the factors included in the CRIS suggest the use of direct behavior interventions in order to remedy deficits in coping resources (Pugh, 1984).

In summary, instruments for assessing coping resources are in the early stages of development. The Ways of Coping and the CSI are both designed to measure specific coping strategies individuals employ to respond to stressors. In contrast, the CRIS employs a 141 item true/false, self-report inventory to assess the stress coping resources individuals perceive they possess to mediate the stress response. Furthermore, the CRIS measures eleven theoretical constructs which may be used to develop interventions to assist individuals in coping more effectively (Pugh, 1984; Wedl, 1986). Therefore, the CRIS has been chosen for inclusion in the present study, which develops an intervention strategy to assist midlife adult children caring for aging parents.

Intervention Strategies for Caregivers

Many midlife adult children provide substantial physical, emotional, social, and economic support to their aging parents (Brody, 1981; Horowitz, 1985). The caregiving situation often results in negative consequences for these

caregivers (Haley et al., 1987). Intervention programs have been designed to reduce negative consequences associated with the caregiving role such as physical and emotional exhaustion, anxiety, low morale, feelings of burden, etc. These programs are generally educational and supportive in nature (Gallagher, 1985).

Systematic use of educational/supportive programs with caregivers of aging parents has only recently been reported in the literature. Additionally, most of the studies which have been conducted using this type of program have not reported enough information to permit the reader to understand the intervention or to evaluate program effectiveness.

Theoretically, these programs are based upon a coping model, in which strategies for gaining accurate information and for increasing the perceived adequacy of one's support network are associated with positive adaptation (Billings & Moos, 1981; Gallagher, 1985; Matheny et al., 1986). A common rationale for this type of program is that if caregivers can be helped to function more effectively in their roles, they are more likely to remain caregivers. As a result, reliance on formal, more expensive, health care systems would be reduced (Gallagher, 1985).

Educational/support programs are usually provided on a time-limited basis by professionals in service and/or university settings or by self-help organizations using

professional input. These programs are generally presented in a small group format consisting of 6-20 individuals per group and meeting on variable time schedules. Each meeting begins with a didactic session followed by a discussion period which allows for group interaction.

Outcomes for education/support programs are generally reported as impressions and do not include information on control groups and specific outcomes. For example, sessions are described as "therapeutic" or enhancing feelings of support (Cohen, 1983; Hausman, 1979; Safford, 1980); caregivers reported that they were "less upset" by the older person's behavior and had more confidence in their own ability to cope (Barens, Raskind, Scott, & Murphy, 1982; Selan & Schuenke, 1982); and more knowledge was reported about specific topics pertinent to aging and caregiving (Brahce, 1983; Peck, 1983).

In summary, the literature related to effectiveness of education/support programs is sparse and primarily impressionistic. However, when pointing out these limitations in their review of the literature, Clark and Rakowski (1983) concluded that "the consensus among reports is that at least short-term benefit has occurred to most participants" (p. 640). Additionally, both Clark and Rakowski (1983) and Gallagher (1985) stated that, given the amount of clinical service of this type being provided to caregivers of older persons, it is troublesome to discover

the lack of controlled research currently available on program impact. Future research efforts need to target assessment of these kinds of programs with experimental rigor so that their scientific value can be determined.

Summary of the Literature Review

Research has documented that the population of older persons, particularly those over age 85, is growing rapidly. This population contains a significant proportion of impaired older persons who require some assistance with activities of daily living to remain as independent as possible in the community.

The literature further documents that family members, particularly midlife children and spouses, provide the required care for impaired older persons. Midlife adult children of aging parents must face several challenges. These include coping with midlife developmental issues, development of filial maturity, and stresses associated with the caregiving role. Emotional issues are consistently documented as the most stressful for caregivers. Because counselors address stress and other emotional issues from a developmental perspective, we are uniquely suited to provide counseling interventions which will meet the needs of midlife adult children caring for aging parents (Miller, 1982; Myers, 1988, 1989).

The counseling needs of adult children caring for aging parents which have been postulated in the literature include

needs in the areas of knowledge, emotional support, and skill development. More specifically, needs which have been identified in the area of knowledge include a need for accurate knowledge of the aging process and knowledge of available community resources (Clark & Rakowski, 1983; McMahon & Ames, 1983; Miller, 1982; Myers, 1988, 1989; Remnet, 1987; Smith, 1989). Needs identified in the area of emotional support include emotional catharsis, normalization and diffusion of feelings, and the need for reassurance (Altschuler, Jacobs, & Shiode, 1984; Clark & Rakowski, 1983; Cutler, 1985; Dobson & Dobson, 1985; Myers, 1989; Wasow, 1986). Needs related to skill development include increased skills in communication, stress reduction, and coping resources (Johnson & Spence, 1982; McMahon & Ames, 1983; Miller, 1982; Myers, 1988, 1989; Remnet, 1987; Smith, 1989).

Outcome measures correlated with these variables (knowledge, emotional support, and skill development) have been proposed in the literature. Knowledge may be measured directly in terms of content and comprehension (Johnson & Spence, 1982). Emotional support has been correlated with perceived level of burden in several studies (Novak & Guest, 1989; Zarit, 1982; Zarit, Todd, & Zarit, 1986). Skill development in the areas of stress reduction and coping resources may be measured as perceived level of stress and perceived coping resources (Smith, 1989; Wedl, 1986).

Despite the identification of counseling needs and correlated outcome measures, little has been done to develop testable intervention strategies based on counseling needs of midlife adult children of aging parents. Such an intervention is needed if we, as counselors, are to adequately address the needs of midlife adult children caring for aging parents. Therefore, the present study was undertaken to develop such an intervention based on the needs of midlife adult children caring for aging parents. This intervention addresses the needs of caregivers in the areas of knowledge, emotional support, and skill development. Additionally, the effectiveness of this intervention was evaluated using an experimental research design.

CHAPTER III METHODOLOGY

The counseling profession has only recently begun to address the needs of adult children caring for their aging parents. Although several programs have been designed and implemented to meet the needs of this population, there is a lack of empirical research investigating the design and effectiveness of such programs.

The current study was designed to: (a) develop a group intervention based on the needs of adult children caring for aging parents, (b) implement the intervention using a control group design, and (c) evaluate the effectiveness of the intervention based upon outcomes in three areas: knowledge, emotional support, and skill development. Three instruments were used to measure these outcomes: (a) the Facts on Aging Quiz - Revised (FAQ-R), (b) the Caregiver Burden Index (CBI), and (c) the Coping Resources Inventory for Stress (CRIS).

The methodology used in the collection and analysis of data is presented in this chapter. Included in this chapter are a statement of the problem, research hypotheses, a discussion of the population and sample, sampling procedures, instrumentation, research design, data

collection procedures, research hypotheses, description of the intervention, and data analyses.

Statement of the Problem

Research has documented that the population of older persons, particularly those over age 85, is growing rapidly. This population contains a significant proportion of impaired older persons who require some assistance with activities of daily living to remain in the community. Family members, particularly spouses and midlife children, provide most of the required care for impaired older persons.

Midlife adult children of aging parents must face numerous challenges. These include their own midlife developmental issues such as the need to achieve filial maturity, and stresses associated with the caregiving role. Additionally, research has documented that adult children caring for aging parents have counseling needs in the areas of knowledge, emotional support, and skill development.

Emotional needs and issues are consistently documented as the most stressful for caregivers. Although relatively little is known about how to address these needs, the negative impact of caregiving stress is well documented. Counselors can play an important role in helping to reduce the negative impact of caregiving stresses. Because counselors address stress and other emotional issues from a developmental perspective, we are uniquely suited to provide

counseling interventions which will meet the needs of midlife adult children caring for aging parents (Miller, 1982; Myers, 1988, 1989).

Despite the identification of counseling needs in the areas of knowledge, emotional support, and skill development, and correlated outcome measures, little has been done to develop testable intervention strategies based on these needs for midlife adult children of aging parents. The importance of developing such a testable intervention, based on the counseling needs of midlife adult children caring for aging parents in the areas of knowledge, emotional support, and skill development, led to the development of the following research hypotheses.

Research Hypotheses

The following hypotheses were tested in the current study:

1. There is no difference in knowledge of the aging process for treatment and delayed treatment groups across the three occasions following group participation as measured by the Facts on Aging Quiz - Revised. Hypotheses 2 through 7 relate to emotional support and were measured by the subscales of the Caregiver Burden Inventory (CBI).
2. There is no difference in perceived level of burden

due to restrictions on the caregiver's time for treatment and delayed treatment groups across the three occasions following group participation.

3. There is no difference in perceived level of developmental burden for treatment and delayed treatment groups across the three occasions following group participation.

4. There is no difference in perceived level of physical burden for treatment and delayed treatment groups across the three occasions following group participation.

5. There is no difference in perceived level of social burden for treatment and delayed treatment groups across the three occasions following group participation.

6. There is no difference in perceived level of emotional burden for treatment and delayed treatment groups across the three occasions following group participation.

7. There is no difference in overall perception of caregiver burden for treatment and delayed treatment groups across the three occasions following group participation.

Hypotheses 8 through 13 relate to skill development and were measured by the subscales of the Coping Resources Inventory for Stress (CRIS).

8. There is no difference in stress monitoring for treatment and delayed treatment groups across the three occasions following group participation.

9. There is no difference in self-disclosure for treatment and delayed treatment groups across the three occasions following group participation.

10. There is no difference in the caregiver's ability to organize and manage resources for treatment and delayed treatment groups across the three occasions following group participation.

11. There is no difference in tension reduction for treatment and delayed treatment groups across the three occasions following group participation.

12. There is no difference in confidence for treatment and delayed treatment groups across the three occasions following group participation.

13. There is no difference in overall perception of coping resources for treatment and delayed treatment groups across the three occasions following group participation.

Population

The population of interest was midlife adult children with parent-care responsibilities. This population included persons who are over age 30 and who are caring for at least one parent who is 60 or more years of age. The sample was drawn from midlife adult children with parent-care responsibilities who reside in Alachua county. If the necessary number of participants (60) could not have been obtained in Alachua county, additional participants would have been obtained in Columbia county and then Bradford

county. These counties were chosen primarily for the convenience of the researcher, population statistics reflect certain commonalities with the total U.S. population.

Alachua county is defined as an urbanized area according to the U.S. Bureau of the Census (1984). Alachua county covers a 902 square mile area and includes the following major communities: Gainesville, High Springs, Alachua, Hawthorne, Newberry, Waldo, Micanopy, and Jonesville. The 1988 total population was estimated to be 182,940. The 1988 population estimate of individuals in the age group 25-64 was 81,467. The 1988 population estimate of individuals in the age group 65+ was 15,260. Although some of the inhabitants of Alachua county have recently relocated to Gainesville to attend the University of Florida, most are long-term residents of the area (Shermyen, 1989).

Although these counties are not representative of the entire United States population, or even the entire population of Florida, they are representative of national population percentages for the age groups 25-64 and 65+ (Shermyen, 1989). Because these counties are representative of the national population percentages in these areas, they were chosen for inclusion in the present study which involves adult children in the age group 25-64 and aging parents in the age group 65+.

Sample and Sampling Procedures

A total sample of 60 caregiving midlife adult children was desired for this study. The proposed sample would have been comprised of four groups of 15 individuals each. Ideally, there would have been a total of 60 group participants, who were at least 40 years of age, who lived in North Central Florida and who were presently caring for an aging parent, aged 60 or older. However, if it was not possible to meet these conditions, a total of 50 group participants who completed all questionnaires and attended all group meetings would be accepted. Additional groups would be added if 50 completers were not contained in the first four groups. Although every attempt would be made to gain 15 participants in each group, due to participants who did not attend or dropped out, the resulting groups may contain unequal numbers of participants.

It was expected that the total sample would consist primarily of adult daughters, as they have been identified in the literature as the most frequent primary caregivers. However, both male and female participants who met the requirements for group participation would have been accepted. Group participants may not have participated in, or could not have been currently participating in, any additional programs, either group or individual, designed to meet the needs of adult children caring for aging parents. Participation was voluntary.

Participants in the study were recruited through newspaper advertisements, local church bulletin advertisements, the Area Agency on Aging, newspaper advertisements, and community college leisure course announcements. The exact wording of the advertisement is provided below in the section entitled "Data Collection Procedures." All volunteers were asked to leave their name and address at the number provided. Each caller was then sent an introductory letter (Appendix A), consent form (Appendix B), and a demographic information sheet (Appendix C) along with a stamped, self-addressed envelope. All information sheets which were returned were screened to ascertain if the respondent met the qualifications for group participation (i.e. they were at least 40 years of age, were currently caring for an aging parent over age 60, and were not receiving counseling aimed at meeting the needs of adult children caring for aging parents). All respondents who met these criteria were included in the subject pool until a minimum of 50 participants had been recruited who met all of the requirements for inclusion in the study, who attended all four group meetings, and who completed all questionnaires.

The names of all qualified volunteers formed a subject pool from which participants in each of the phases of the study were selected (treatment or delayed treatment). Each participant was given a subject number and assigned to one

of five groups (group five was added to obtain the minimum number of completers). Group assignment was based upon a computer-generated list of random numbers which was obtained prior to the beginning of the proposed study. This allowed random assignment of individuals to each group. Individuals in groups 1, 3, and 5 were assigned to treatment groups and individuals in groups 2 and 4 were assigned to delayed treatment groups.

Instrumentation/Variables

The variables measured in the study were based upon counseling needs of midlife adult children caring for aging parents which have been identified in the literature. These included needs in three areas: knowledge, emotional support, and skill development. Specifically, variables chosen to represent needs in each of these areas included knowledge, burden, and coping resources. Instruments used to measure these variables, that were not copyrighted, are located in the appendices. Appendix D contains a copy of the FAQ-R and Appendix E contains a copy of the CBI. The CRIS, because it is copyrighted material, is not included and can be obtained from the authors cited. Demographic information was also obtained on a demographic information sheet (Appendix C) and was used to describe the sample.

Demographic information of interest included the caregiver's age, gender, race, employment, income level, marital status, number of children, children's ages, number

of children residing at home, number of parents receiving care, length of time caring for parents, and average number of hours per week spent caring for a parent. Demographic information of interest also included the parent's age, place of residence, level and type of impairment, and length of impairment.

Facts on Aging Quiz - Revised

Knowledge was assessed utilizing the Facts on Aging Quiz - Revised (Miller & Dodder, 1980). The Facts on Aging Quiz was originally developed by Palmore in 1977 in response to substantive and psychometric inadequacies of earlier attitude measures (e.g., Tuckman-Lorge Scale and Kogan, Attitudes Toward Old People Scale). This scale is a short (25 item), paper and pencil instrument, designed to measure knowledge about older people.

In 1980, Miller & Dodder revised the Facts on Aging Quiz (Appendix D) in answer to criticisms of this instrument. One of the major revisions was to remove ambiguous terminology. The revised scale replaced the term "most" with the term "majority" which was defined as "more than half." Having been defined in such a manner, the concept "majority" is less open to individual interpretation than when the term "most" was used and the same definition serves as a point of reference consistently throughout the questionnaire.

Another revision made by Miller and Dodder (1980) included modifying six questions which were "double-barreled." These questions were questions which referred to two distinct concepts and therefore, the researcher could not be sure to which one the subject was referring when answering. In an attempt to avoid these "double-barreled" statements, only one key concept was kept in each question. Item 13 was totally omitted due to the difficulty in concluding the "correct" answer from current research which is ambiguous. Item 21 was also modified to replace the statement "defined by Federal Government" with the actual governmental monetary guideline values (Miller & Dodder, 1980).

The FAQ-revised (Miller & Dodder, 1980) is short (24 items), is confined to factual statements, and each item is documented by empirical research (Palmore, 1988). It was designed to cover basic physical, mental, and social facts related to aging. Scoring is based on the number of correct responses using a "true" or "false" answer format. There is no time limit for completion.

Group reliability for the FAQ is high, as shown by test-retest data gathered by Laner (1981). Validity studies, also completed by Laner (1981), compared two groups of 46 students in social gerontology and human ecology classes. Students in the social gerontology class evidenced a significant increase in knowledge as measured by the FAQ

with a chi-square significant at the .001 level. Comparison group means were almost identical on test/retest, 15.05 and 16.05 respectively.

Scores may be interpreted as number of correct responses. The higher the number of correct responses, the more accurate the knowledge possessed by the respondent toward older persons.

Caregiver Burden Index

Novak and Guest (1989) developed a multidimensional measure of caregiver burden, the Caregiver Burden Inventory (CBI), which was designed to overcome many of the criticisms of previous similar measures. The CBI (Appendix E) is a short, paper-and-pencil instrument composed of five subscales which include time-dependence burden, developmental burden, physical burden, social burden, and emotional burden. The definitions of the 5 subscales of the CBI are included here:

1. Time-dependence Burden is defined by the authors as the caregiver's perception of burden due to restriction of the caregiver's time.

2. Developmental Burden is defined by the authors as the caregiver's perception of burden due to the caregiver's feelings of being "off-time" in his or her development with respect to peers.

3. Physical Burden is defined by the authors as the caregiver's perception of burden due to the caregiver's feelings of chronic fatigue and damage to physical health.

4. Social Burden is defined by the authors as the caregiver's perception of burden due to the caregiver's feelings of role conflict.

5. Emotional Burden is defined by the authors as the caregiver's perception of burden due to the caregiver's negative feelings toward their care receivers.

The factors underlying each of the subscales have been empirically verified through a series of factor analyses. Each subscale consists of five questions, with the exception of the physical burden scale which contains four questions, resulting in a total of twenty-four items. Each item is rated on a scale of 0 (not at all descriptive) to 4 (very descriptive). A subject's score on each scale may range from 0 to 20, with the exception of scale 3, Physical Burden (with only four items), where scores could range from 0 to 16. Physical burden scores can be adjusted by multiplying the obtained score out of 16 by 1.25 to give an equivalent score out of 20. An overall burden score can also be obtained by adding the responses to all items on the scale. There is no time limit for administration.

Normative data for the CBI were derived from 107 caregivers of older people, 28 men and 79 women. Caregiver's ages ranged from 25 to 87 years with a mean of

60. On average, caregivers reported caring for their care receivers for 63 months. The impaired care receivers' ages ranged from 56 to 93 with a mean of 77.

The CBI subscales and overall score produce good internal consistency coefficients ranging from .85 to .77. Validity is primarily content in nature. Face validity is also high.

Coping Resources Inventory for Stress

The fifth edition of the Coping Resources Inventory for Stress, which was utilized in the current study, was developed by Matheny, Curlette, Aycok, Pugh, & Taylor (1984) to assess an individual's perceived coping resources. It is a paper-and-pencil instrument which consists of 141 items in a True/False format. Scores may be obtained on eleven subscales and an overall Coping Effectiveness Score (CES) may also be obtained. Each of the subscales represents a cluster of coping skills and other resources for coping with stress. The factors for each of the subscales have been empirically verified through a series of factor analyses (Pugh, 1984).

The definitions of the 11 subscales of the CRIS are included here:

1. Stress Monitoring is an evaluative dimension of the respondent's awareness of personal stress and tension build-up and awareness of situations and events which are likely to prove stressful.

2. Self-Disclosure is an evaluative dimension of the respondent's willingness to share honestly his or her feelings, thoughts, and opinions with others.

3. Structuring is an evaluative dimension of the respondent's ability to organize and manage resources such as time, energy, and money.

4. Social Support is an evaluative dimension of the respondent's ability to measure the availability of family and friends who may act as a buffer against stress.

5. Flexibility is an evaluative dimension of the respondent's ability to measure the degree of rigidity in his or her thinking.

6. Tension Reduction is an evaluative dimension of the respondent's ability to measure the degree of ability to lower arousal through relaxation procedures and thought control.

7. Confidence is an evaluative dimension of the respondent's ability to measure his/her ability to cope successfully with stress.

8. Acceptance is an evaluative dimension of the respondent's acceptance of personal imperfections.

9. Physical Fitness is an evaluative dimension of the respondent's personal health practices as they relate to exercise, proper weight, and energy levels.

10. Wellness is an evaluative dimension of the respondent's overall health and wholeness, including the

absence of chronic disease and disabilities as well as the possession of habits making for good health.

11. Problem Solving is an evaluative dimension of the respondent's problem-solving skills which include defining problems, obtaining information, gathering opinions from others, determining consequences, considering alternatives, and evaluating time limitations for problem resolution.

The standardization sample of the 5th version of the CRIS is based upon the responses of 1201 participants. This group consisted of graduate and undergraduate students, state and federal government employees in both white and blue collar positions, and business executives from the private sector. Information about the ages of the participants in the norming group was not available.

Two reliability studies have been conducted on the fifth edition of the CRIS ($N = 1327$). Test-retest coefficients on the subscales and the overall coping score yielded reliability scores ranging from .60 to .87. Internal consistency results ranged from .73 to .88. Content validity was determined by five independent raters who rated the inventory for adequacy of taxonomy representation. Results of this study indicated raters were in agreement with inventory constructors 90% of the time (Matheny et al., 1984).

Permission to administer the CRIS for research purposes was obtained from the primary author, Dr. Kenneth Matheny.

The CRIS is currently being published and distributed by Health Prisms Publishing Company. It is a copyrighted instrument and photocopies may not be included in the dissertation. Scoring is also done by Health Prisms Publishing Company. Each participant receives an individual printout of his or her scores on the subscales. The score includes the percent score and the percentile rank which is based on the norming population discussed above.

Research Design

Data collection occurred in two phases. A diagram which describes the entire research design follows.

Phase I

	<u>Week 0</u>	<u>Week 1</u>	<u>Week 2</u>	<u>Week 3</u>
Treatment groups (2)	0	X	X	X
Control groups (2)	0			

Phase II

	<u>Week 4</u>	<u>Week 5</u>	<u>Week 6</u>	<u>Week 7</u>
Treatment groups (2)	X0			0
Control groups (2)	OX	X	X	X0
Treatment group added	OX	X	X	X0

(0 = collect data, X = treatment)

In this way, a delayed treatment, control group design was employed while providing the additional advantages of study replication and evaluation of treatment effectiveness after a 4 week time interval.

Data Collection Procedures

Data collection began with the placement of advertisements in local media to contact research participants. These advertisements were placed in the Alligator (an independent newspaper targeted at University of Florida students and faculty), church bulletins sent to all churches in Alachua County, the Mid-Florida Area Agency on Aging, the Williams Thomas Television Bulletin Board Announcements, and Santa Fe Community College's Community Courses Bulletin. The advertisement read as follows:

Wanted - Adult children caring for aging parents to participate in a group study designed to meet the needs of persons caring for impaired older persons. Participants must be at least 40 years of age, responsible for the care of a parent at least 60 years of age or older, and not currently participating in any other group or individual therapy designed to meet the needs of adult children caring for aging parents. For more information, call (telephone #.)

Initial Contact

Volunteers responded to the advertisements by calling the number provided. All volunteers were asked to leave their name and address at the number provided. Each caller was then sent an introductory letter (Appendix A), consent form (Appendix B), and a demographic information sheet (Appendix C) along with a stamped, self-addressed envelope.

All information sheets which were returned were screened to ascertain if the respondent met the qualifications for group participation (i.e. at least 40 years of age, currently caring for an aging parent over age 60, and have not received counseling addressing the needs of adult children caring for aging parents). If they did not meet the criteria for study participation, they were given the number of the Center for Aging Resources to obtain further information regarding other possible sources of support for caregivers in North Central Florida.

If volunteers did meet the requirements for study participation, they were sent a packet containing the FAQ-R, the CBI, and the CRIS with instructions to complete the forms and return them in the enclosed stamped, self-addressed envelope before the first group meeting. Additionally, participants were told that completion of these forms was necessary in order to gain information regarding their current caregiving situation. If they did not return the completed instruments before the initial group meeting, they were not allowed to participate in the study.

As previously discussed, each volunteer who met the criteria for group participation was given a subject number and assigned to one of five groups based upon a computer-generated list of random numbers. Individuals in groups 1, 3, and 5 were assigned to treatment groups and individuals

in groups 2 and 4 were assigned to delayed treatment groups.

Based upon their group assignment, participants were told when and where groups were scheduled to meet upon receipt of their completed questionnaires. All participants were asked to make a commitment to meet for two hours, once a week, for a total of four weeks.

The required number of participants (N=51) were obtained in Alachua County, therefore, all groups were held in Gainesville. Several possible sites had been identified for group meetings including the University of Florida, Santa Fe Community College, and Trinity Methodist Church.

Data collection was comprised of two phases. These are discussed below.

Phase I

The first phase consisted of completion of the informed consent form (Appendix B), and demographic information sheet (Appendix C). Initial administration of the FAQ-R (Appendix D), the CBI (Appendix E), and the CRIS also occurred at this time. Completion of phase one data collection took participants approximately 90 minutes and was completed prior to the first group meeting. Participants in groups 1, 2, 3, and 4 completed the first phase.

Participants in groups 2 and 4 (delayed treatment groups) were asked to again complete the FAQ-R, CBI, and CRIS during the first session of their groups which were scheduled to begin following completion of the treatment

groups (week 4). They were told that this information was necessary to ascertain if their caregiving situation had changed appreciably since they first completed the questionnaires approximately 8 weeks earlier.

An additional treatment group, group 5, was added during week 4 in order to gain enough participants to meet the required 50 subjects. Participants in this group also completed all instruments at this time before beginning treatment.

Phase II

Phase 2 of data collection occurred at week 4 for groups 1 and 3 who completed retesting on the FAQ-R, CBI, and CRIS at the end of the last group meeting. Phase 2 data collection occurred at week 7 for groups 2, 4, and 5 who completed retesting on the FAQ-R, CBI, and CRIS at the end of the last group meeting. All participants were told that completion of these measures a second time was to assist the researcher in evaluating the effectiveness of group participation in meeting the needs of adult children caring for aging parents.

Additionally, participants were asked to complete a short follow-up questionnaire (Appendix F) which asked caregivers if there had been any significant changes in the caregiving relationship or if they had experienced any significant life events since group participation began. Examples of such changes include placement of the parent in

a nursing home, increased impairment of the parent such as a stroke, or loss of a job by the caregiver. This information was necessary in order to account for intervening variables which may have affected research outcomes. This follow-up questionnaire was administered at week 4 for all groups participating in the study. It was also administered again to groups 2, 4, and 5 at week 7.

Additionally, participants in groups 1 and 3 were mailed the FAQ-R, CBI, CRIS, and short follow-up questionnaire during week 7. Participants were asked to complete these measures for a third time. They were told this information was necessary in order for the researcher to evaluate the long-term effects of group participation.

Description of Intervention

The psychoeducational counseling intervention which was implemented in the study was comprised of four, 2 hour, weekly sessions. Each session was conducted by this researcher and was designed to cover specific areas that effect parent-child relationships, as explained below.

Session I

The first 30 minutes of Session I were used to make introductions, present an overview of group topics, and discuss confidentiality. A verbal contract was made with all group participants to keep personal information shared in the class confidential.

The remaining 90 minutes were spent discussing facts related to the normal aging process. This information was presented in a lecture format using an overhead projector and a handout containing information on age-related changes was given (Appendix G). The purpose of this session was to provide the class with useful information about the numerous factors involved in the aging process; to encourage participants to develop empathy for their aging parents; and to invite participants to consider their own aging (Billings & Moos, 1981; Gallagher, 1985).

Specific material to be covered included changes in each body system: the skin, musculoskeletal system, nervous system, respiratory system, cardiovascular system, gastrointestinal system, and, genito-urinary system. Age-related changes in the five senses were also included in this discussion. Changes were listed, described in terms of frequency of occurrence, and possible impacts on the aging person discussed. The remainder of Session I consisted of a question and answer period focusing on material presented in the session (Clark & Rakowski, 1983; McMahon & Ames, 1983; Miller, 1982; Remnet, 1987; Smith, 1989).

Session II

Session II focused on improving communication skills within the family by presenting material in a lecture/discussion format, using overhead transparencies, and demonstrating effective communication skills by

utilizing a group exercise. Additionally, a handout was given containing information on communication skills and instructions for the group exercise (Appendix H).

Specific information presented in the first hour included a definition of what was meant by communication, the importance of effective communication; barriers to effective communication experienced when communicating with older persons, including physical, psychological, and attitudinal factors; and the essential components of effective communication (empathy, genuineness, and positive regard).

Information was also presented regarding communication skills in two areas: attending behaviors and facilitative responses. Attending behaviors were discussed in terms of body language and voice cues as well as verbally following the older person to demonstrate that the caregiver is really listening and trying to understand. Examples were given of verbal following and attending behaviors. Facilitative responses were discussed in six areas including advice, interpretation, reassurance, questioning, summary, and reflection. Examples of each type of response were given.

Participants were then divided into groups of three to practice communication skills. One participant took the role of talker, one the role of facilitator, and one the role of observer. This took approximately 20 minutes.

In addition to communication skills, the second hour of Session II focused on family issues by engaging in a group discussion of issues such as the relationship between the adult child and the aging parent, the relationship between the adult child caring for the aging parent and siblings, and the adult child's own family. This discussion was initiated by the group leader using stimulus questions such as: What is the overall history of the caregiving relationship? Is the caregiver being a caregiver by choice, or was he or she designated caregiver by some family member? Do other siblings live close by? Do they participate in caregiving? How are disagreements handled? What is the caregiver's relationship with his or her spouse and children? How much do the spouse and children participate in caregiving?

The group was then broken up into three groups of five. Each group was asked to discuss their own situations using the stimulus questions as a guide. This led to exchanges between group members who shared similarities with their own experiences and/or offered advice on specific problems which have emerged in their life as a child of an aging parent.

Obviously, 2 hours was not enough time to cover these two important topics in any depth. However, my purpose for including this session was not so much to give answers and factual information as it was to provide participants with a useful framework for thinking about their situation.

Through the examination of family dynamics and communication patterns, participants gained a better picture of how these areas were presently influencing their situation.

Session III

Session III focused on stress and time management.

Because stress was documented as the most difficult area for caregivers to handle, general stress and time management techniques were presented in this section. The first hour, presented in lecture format with overhead transparencies, included signs and symptoms of stress, varying approaches to reduce stress, and the importance of total wellness and self-care.

The information presented included a definition of stress and three sources of stress (mind, body, and situation). Suggestions for handling stress in each of these areas was given. For example; for mind stress, participants were encouraged to catch themselves jumping to conclusions or taking things personally; to ask themselves "Will it really matter five years from now?"; to challenge their unreasonable shoulds, oughts, musts, owes, and deserves; and to use thought-stopping by mentally yelling, "Stop", seeing a red light, or hearing a whistle. Suggestions for relaxing mind stress included using positive imagery, finding health enhancing phrases and repeating them, laughing at yourself, and using "instant preplays" and "instant replays" to improve performance. Suggestions for

handling body stress included breathing exercises, progressive relaxation, smoking cessation, weight control, and regular exercise. Situational stress reduction suggestions included making healthy changes in your surroundings to reduce stressful noise, odors, objects, and lighting; asking assertively for what you need; learning to say no; scheduling less time in stressful situations; taking breaks; engaging community resources; and managing time effectively.

The second hour consisted of a discussion of time management techniques and participants were encouraged to share information related to the effects of stress on their lives and approaches to dealing with it. This portion of the third session was presented in a group discussion format. Participants were asked to share time management techniques and stress reduction techniques which had worked for them. The final twenty minutes of the group included a practice exercise in progressive relaxation using an audiotape (Appendix I). This exercise consisted of the group leader leading the participants in practicing progressive relaxation. This included identifying a body area, tensing this area, and then relaxing each area until the entire body is relaxed.

Session IV

Session IV, the final session, began with a discussion of developmental issues related to mid and late life and was

presented in a lecture/group discussion format using overhead transparencies. This included information presented in Chapter II related to these areas. The issues of midlife including generativity versus stagnation, and the issues of late life including ego integrity versus despair, were discussed with regard to their impact on relationships between individuals in both life stages. Differences and similarities in tasks faced in both life stages were discussed as well as implications for the caregiving situation. The position of "Sandwich Generation" was discussed as well as the impact of societal position for persons in mid and late life. For example, persons in midlife are generally experiencing their peak economic and power positions whereas persons in late life are generally experiencing declining economic and power positions. This session took approximately 45 minutes.

Following this discussion, information on available community resources was presented. This took approximately 30 minutes and included a review of a handout of available community resources distributed by the Mid-Florida Area Agency on Aging. Community resources were also discussed in terms of services provided, eligibility requirements, and method of contact. This information may be accessed by contacting the local Area Agency on Aging. This agency can provide information related to all services for older persons in the area. Also, a community information hotline

may be available in some cities. The overall purpose of this information is to assist participants in gaining access to all services which can assist them in their caregiving role. The remaining 45 minutes of Session IV consisted of a wrap-up and post-test administration of each of the measures included in the study.

Data Analyses

The resulting sample is described in Chapter IV using frequency tabulations obtained from the demographic questionnaires. Group means and standard deviations for each of the instruments (FAQ-R, CBI, and CRIS) and the subscales are tabulated for pre-test, retest, post-test, and follow-up administrations.

A repeated measures analysis of variance and follow-ups by occasion are utilized to examine the relationship between pre-test and post-test scores on each of the measures, treatment effects, and the interaction of pre-test/post-test scores and treatment effects across groups. Due to a low N on the third occasion, a simple analysis of covariance is also included to examine the data.

The delayed treatment groups, 2 and 4, act as control groups as well as a replication of the study. An alpha level of .05 is used to determine statistical significance of the results of data comparisons.

CHAPTER IV RESULTS

The results of the sampling procedures and analyses of the data are presented in this chapter. Each of the hypotheses is stated and examined in regard to the results produced by the analyses. The results of the demographic questionnaire are also stated and examined in relation to the results of the data analyses. The significance level, alpha, was set at .05 for this study.

Resulting Sample

Characteristics of Subjects

Four instruments (the FAQ, the CBI, the CRIS, and the demographic data questionnaire) were administered to a total of 70 adult children caring for aging parents who agreed to participate. When incomplete questionnaires were excluded, a data base of 51 participants remained. The primary criteria for inclusion in the study were age of the caregiver (at least 40 years of age), age of the parent (at least 60 years of age), and the caregiver could not currently be participating in counseling to meet the needs of adult children caring for aging parents. All participants resided in Alachua County, Florida. A total of 70 participants attended all or some of the groups. Groups I, II, and IV initially began with 15 participants each;

Group III had 14 participants initially; and Group V had 11 participants initially.

Table 1 provides an analysis of the sample on the basis of selected demographic characteristics. As can be seen from this table, the total sample included 7 male caregivers and 44 female caregivers. Though not shown in the table, the caregivers were between the ages of 54 and 72 with a mean age of 63.5 years. All of the caregivers in the study identified themselves as white when asked their ethnic origin. With regard to employment, 37% of the caregivers reported they were employed either full-time (16%) or part-time (21%) and 63% reported they were unemployed. Only 15 of the 49 caregivers reported that caregiving had affected their employment.

Further analysis of Table 1 reveals that 29% of the caregivers stated their annual income ranged between 0 - \$15,999, 45% stated their annual income ranged between \$16,000 and \$25,999, 14% stated their annual income ranged between \$26,000 and \$35,999, 10% stated their annual income ranged between \$36,000 and 49,999, and only 2% stated their annual income was above \$50,000.

Table 1 also indicates that 28% of the caregivers were married, 10% were single, 31% were divorced, and 31% were widowed. The number of children each caregiver reported ranged from 0 to 5. The most frequently occurring number of

Table 1

Demographic Characteristics of Sample Population (N=51)

Category	Sample N	% Total
Caregiver Sex		
Male	7	14
Female	44	86
Ethnicity		
White	51	100
Employment		
Unemployed	32	63
Part-time	11	21
Full-time	8	16
Is work affected		
Yes	15	29
No	32	63
Income		
\$0 - 15,999	15	29
\$16,000 - 25,999	23	45
\$26,000 - 35,999	7	14
\$36,000 - 49,999	5	10
\$50,000 - up	1	2
Marital Status		
Married	14	28
Single	5	10
Divorced	16	31
Widowed	16	31
Separated	0	0
# of Children		
0	12	23.5
1	8	16
2	15	29
3	12	23.5
4	1	2
5	3	6

Table 1 -- continued

Category	Sample N	% Total
# of Children at home		
0	47	92
1	3	6
2	1	2
Parent Cared For		
Mother	41	80
Father	10	20
Parent Residence		
With Caregiver	24	47
Own Home	16	31
Other	11	22
Prior Counseling		
Yes	2	4
No	49	96

children was 2. Forty-seven caregivers reported no children currently living at home whereas 3 caregivers reported one child currently living at home, and 1 caregiver reported two children currently living at home.

Additionally, Table 1 indicates 80% of the caregivers reported caring for an aging mother whereas 20% reported caring for an aging father. Forty-seven percent of the caregivers reported their parent resided in their home, 31% reported their parent resided in their own home, and 22% reported their parent resided in another type arrangement, which included nursing homes or adult congregate living facilities.

The demographic data questionnaire also indicated that of the 51 participants who completed all of the questionnaires and attended all group meetings, only 2 reported any previous experience in a counseling setting. None of the participants were currently in counseling for any reason.

Characteristics and Responses of Nonparticipants

Nonparticipants included those persons who were excluded from participation in this study because they did not meet the following criteria: (a) at least 40 years of age; (b) caring for an aging parent who was at least 60 years of age; and (c) were not currently enrolled in any other therapy designed to address the needs of adult children caring for aging parents. These individuals were

given the telephone number of the Mid-Florida Area Agency on Aging Senior Helpline for referral to additional services.

Also included in the nonparticipants group were individuals who did not attend all group meetings or who did not complete all questionnaires. A variety of reasons were given for not completing all questionnaires. These included the length of the questionnaires; difficulty reading or writing due to illiteracy, poor eyesight or other physical impairment; participant feelings that the information requested was too personal; and participant feelings that the information requested was redundant (i.e. "They asked the same question 15 different times. Didn't they believe me?").

A variety of reasons were also given for not attending all four group sessions. These included illness of caregiver or parent; lack of another caregiver to stay with parent while primary caregiver attended; and fatigue of caregiver.

Characteristics and Responses of Participants

A total of 70 participants attended all or some of the group sessions, however, only 51 participants completed all of the questionnaires and attended all group meetings. Of the 19 participants who did not complete all questionnaires and/or attend all group meetings, 2 were males and 17 were females. More specifically, of the 15 individuals who initially attended Group I, only 11 completed all sessions

and all questionnaires; of the 15 individuals who initially attended Group II, only 12 were completers; of the 14 individuals who initially attended Group III, only 9 were completers; of the 15 individuals who initially attended Group IV, only 10 were completers; and of the 11 individuals who initially attended Group V, only 9 were completers. Nine of the 19 non-completers did not attend all group meetings and 11 of the non-completers did not complete all questionnaires.

Respondents agreed to participate in the study for a variety of reasons. Some participated because they had been caring for an aging parent and the parent was becoming increasingly worse and they were beginning to feel burdened and needed to become aware of additional resources. Some participated because a parent had suddenly become ill and they had only recently accepted the caregiving role. Others had recently helped a previously independent parent move into the caregiver's home or a nursing home and were having difficulty dealing with these arrangements. All participants agreed they came to the group to gain more knowledge related to the caregiving role, community resources, and aging in general.

Problems in Administration

The length of the four instruments was the major difficulty noted by the researcher. Many participants in the control groups resented being asked to complete these

questionnaires once and then being asked to complete them a second time before being allowed to participate in a group. These participants were told that completion of the questionnaires would allow the researcher to ascertain if their caregiving situation had changed significantly since the first administration. Participants in the treatment groups seemed to accept completion of the instruments prior to group participation and immediately following group participation. However, follow-up questionnaires sent after a time lapse following group participation produced a very low return rate (28%).

Results and Discussion of the Hypotheses

The Facts on Aging Quiz - Revised was scored by the researcher. Each correct question counted as one point. The total number of correct responses constituted the total score.

Results of Hypothesis I - FAQ-R

Hypothesis I stated there is no difference in knowledge of the aging process for treatment and delayed treatment groups across the three occasions following group participation as measured by the Facts on Aging Quiz - Revised. Means and standard deviations are reported in Table 2. As can be seen in Table 2, means on the FAQ-R for the treatment group were 16.0 (S.D. = 2.3) on the pre-test, 18.6 (S.D. = 2.2) on the post-test, and 19.0 (S.D. = 1.8) on the follow-up. Means for the control group were 15.5 (S.D.

Table 2

Facts on Aging Quiz (Revised) Group Results

Group	N	Mean	Std. Dev.
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Treatment			
Pre-test	29	16.0	2.3
Post-test	29	18.6	2.2
Follow-up	8	19.0	1.8
Control			
Pre-test	22	15.5	2.5
Retest	22	14.7	2.7
Post-test	22	18.5	2.7

= 2.5) on the pre-test, 14.7 (S.D. = 2.7) on the retest prior to treatment, and 18.5 (S.D. = 2.7) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 3. As can be seen from this analysis, a significant difference was found between the treatment and control groups by occasion at the .05 level. Therefore, hypothesis I was rejected. There is a difference between the treatment and control groups in knowledge of the aging process as measured by the Facts on Aging Quiz - Revised across occasions. Furthermore, there is an increase in knowledge of the aging process as measured by the FAQ-R following group participation (i.e., the lone significant difference was at the end of phase I).

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA) was also used to examine the FAQ-R scores. The results of this analysis are reported in Table 4. This analysis was also significant at the .05 level.

Results of Hypothesis II through VII - CBI

Hypotheses II through VII are presented below. All of these hypotheses were measured using scores obtained on the CBI.

Hypothesis II. Hypothesis II stated there is no difference in perceived level of burden due to restrictions

Table 3

Repeated Measures ANOVA and Follow-ups by Occasion for FAQ-R

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	46.91	46.91	3.04	0.09		
Error	28	432.75	15.46				
Within Subjects Effects							
Time	2	127.29	63.64	55.38	0.0001*	0.0001	0.0001
Time x TRT+++	2	77.16	38.58	33.57	0.0001*	0.0001	0.0001
Error	56	64.3					

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

* p < 0.05

Table 3 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
FAQ1		
Pretest	0.17	0.86
FAQ2		
Post-test/retest	4.46	0.0001*
FAQ3		
Follow-up/post-test	0.49	0.63

* $p < 0.05$

Table 4

Results of ANCOVA for FAQ-R

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
Model	2	338.96	169.48	60.02	
Error	48	135.55	2.82		
Total	50	474.51			
Pre-FAQ	1	148.26		52.50	0.0001*
Treatment	1	158.15		56.00	0.0001*

Note:

*p < .05

on the caregiver's time for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the time-dependence scale of the Caregiver Burden Inventory (CBI). Means and standard deviations are reported in Table 5. As can be seen in Table 5, means on the CBI time-dependence scale for the treatment group were 4.8 (S.D. = 4.8) on the pre-test, 4.3 (S.D. = 4.2) on the post-test, and 3.9 (S.D. = 2.9) on the follow-up. Means for the control group were 4.1 (S.D. = 2.9) on the pre-test, 4.2 (S.D. = 2.9) on the retest prior to treatment, and 3.4 (S.D. = 2.5) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 6. As can be seen from this analysis, no significant difference was found between the treatment and control groups at the .05 level. Therefore, hypothesis II was not rejected. There is no difference in perceived level of burden due to restrictions on the caregiver's time following group participation as measured by the time-dependence scale of the CBI.

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA) was also used to examine the CBI time-dependence scores. The results of this analysis are reported in Table 7. This analysis was also not significant at the .05 level.

Table 5

Caregiver Burden Inventory Time Dependence Scale Group Results

Group	N	Mean	Std. Dev.
Treatment			
Pre-test	29	4.8	4.8
Post-test	29	4.3	4.2
Follow-up	8	3.9	2.9
Control			
Pre-test	22	4.1	2.9
Retest	22	4.2	2.9
Post-test	22	3.4	2.5

Table 6

Repeated Measures ANOVA and Follow-ups by Occasion for CBI - Time
Dependence Scale

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	0.00	0.00	0.00	0.99		
Error	28	623.12	22.25				
Within Subjects Effects							
Time	2	3.57	1.78	3.03	0.06	0.07	0.07
Time x TRT+++	2	3.48	1.74	2.96	0.06	0.08	0.07
Error	56	32.90	0.59				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed Treatment Effect

Table 6 -- continued

Occasion	t	PR> t
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Within Occasion Follow-up t-tests

CBI1

Pretest	0.1	0.93
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CBI2

Post-test/retest	0.52	0.61
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CBI3

Follow-up/post-test	0.42	0.67
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Table 7

ANCOVA - CBI-Time Dependence Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
Model	2	503.21	251.61	73.92	
Error	48	163.38	3.40		
Total	50	666.59			
Pre-CBI	1	503.04		147.79	0.0001
Treatment	1	2.43		2.43	0.4025

Hypothesis III. Hypothesis III stated there is no difference in perceived level of developmental burden for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the developmental burden scale of the Caregiver Burden Inventory (CBI). Means and standard deviations are reported in Table 8. As can be seen in Table 8, means on the CBI developmental burden scale for the treatment group were 5.6 (S.D. = 4.9) on the pre-test, 5.0 (S.D. = 4.6) on the post-test, and 4.9 (S.D. = 2.7) on the follow-up. Means for the control group were 5.2 (S.D. = 3.3) on the pre-test, 5.0 (S.D. = 3.2) on the retest prior to treatment, and 4.0 (S.D. = 2.7) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 9. As can be seen from this analysis, no significant difference was found between the treatment and control groups at the .05 level. Therefore, hypothesis III was not rejected. There is no difference in perceived level of developmental burden following group participation as measured by the developmental burden scale of the CBI.

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA) was also used to examine the CBI developmental burden scores. The results of this analysis are reported in Table

Table 8

Caregiver Burden Inventory Developmental Burden Scale Group Results

Group	N	Mean	Std. Dev.
Treatment			
Pre-test	29	5.6	4.9
Post-test	29	5.0	4.6
Follow-up	8	4.9	2.7
Control			
Pre-test	22	5.2	3.3
Retest	22	5.0	3.2
Post-test	22	4.0	2.7

Table 9

Repeated Measures ANOVA and Follow-up by Occasion for CBI - Developmental Burden Scale

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	0.71	0.71	0.03	0.87		
Error	28	753.75	26.92				
Within Subjects Effects							
Time	2	6.76	3.38	3.30	0.04	0.06	0.06
Time x TRT+++	2	3.87	1.93	1.89	0.16	0.17	0.17
Error	56	57.31	1.02				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

Table 9 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
CBI1		
Pretest	0.00	0.96
CBI2		
Post-test/retest	0.92	0.82
CBI3		
Follow-up/post-test	0.71	0.49

10. This analysis was also not significant at the .05 level.

Hypothesis IV. Hypothesis IV stated there is no difference in perceived level of physical burden for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the physical burden scale of the Caregiver Burden Inventory (CBI). Means and standard deviations are reported in Table 11. As can be seen in Table 11, means on the CBI physical burden scale for the treatment group were 5.3 (S.D. = 3.5) on the pre-test, 5.1 (S.D. = 3.5) on the post-test, and 6.3 (S.D. = 2.9) on the follow-up. Means for the control group were 4.9 (S.D. = 3.2) on the pre-test, 5.2 (S.D. = 3.2) on the retest prior to treatment, and 4.6 (S.D. = 2.5) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 12. As can be seen from this analysis, no significant difference was found between the treatment and control groups at the .05 level. Therefore, hypothesis IV was not rejected. There is no difference in perceived level of physical burden following group participation as measured by the physical burden scale of the CBI.

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA)

Table 10

ANCOVA - CBI - Developmental Burden Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
<hr/>					
Model	2	613.10	306.55	75.89	
Error	48	193.88	4.04		
Total	50	806.98			
Pre-CBI	1	613.07		151.78	0.0001
Treatment	1	1.53		0.38	0.5408

Table 11

Caregiver Burden Inventory Physical Burden Scale Results

Group	N	Mean	Std. Dev.
Treatment			
Pre-test	29	5.3	3.5
Post-test	29	5.1	3.5
Follow-up	8	6.3	2.9
Control			
Pre-test	22	4.9	3.2
Retest	22	5.2	3.2
Post-test	22	4.6	2.5

Table 12

Repeated Measures ANOVA and Follow-ups by Occasion for CBI - Physical Burden Scale

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	3.64	3.64	0.15	0.70		
Error	28	695.70	24.85				
Within Subjects Effects							
Time	2	5.44	2.72	1.59	0.21	0.22	0.22
Time x TRT+++	2	12.87	6.43	3.76	0.03	0.04	0.04
Error	56	95.73	1.71				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

Table 12 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
CBI1		
Pretest	0.17	0.86
CBI2		
Post-test/retest	0.00	0.97
CBI3		
Follow-up/post-test	1.54	0.13

was also used to examine the CBI physical burden scores. The results of this analysis are reported in Table 13. This analysis was also not significant at the .05 level.

Hypothesis V. Hypothesis V stated there is no difference in perceived level of social burden for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the social burden scale of the Caregiver Burden Inventory (CBI). Means and standard deviations are reported in Table 14. As can be seen in Table 14, means on the CBI social burden scale for the treatment group were 4.6 (S.D. = 3.9) on the pre-test, 4.2 (S.D. = 3.4) on the post-test, and 5.8 (S.D. = 4.6) on the follow-up. Means for the control group were 4.3 (S.D. = 2.9) on the pre-test, 4.8 (S.D. = 3.0) on the retest prior to treatment, and 4.5 (S.D. = 2.4) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 15. As can be seen from this analysis, no significant difference was found between the treatment and control groups at the .05 level. Therefore, hypothesis V was not rejected. There is no difference in perceived level of social burden following group participation as measured by the social burden scale of the CBI.

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA)

Table 13

ANCOVA - CBI - Physical Burden Scale Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
Model	2	361.51	180.75	45.72	
Error	48	189.79	3.95		
Total	50	551.29			
Pre-CBI	1	361.35		91.39	0.0001
Treatment	1	2.46		0.62	0.4345

Table 14

Caregiver Burden Inventory Social Burden Scale Group Results

Group	N	Mean	Std. Dev.
<hr/>			
Treatment			
Pre-test	29	4.6	3.9
Post-test	29	4.2	3.4
Follow-up	8	5.8	4.6
Control			
Pre-test	22	4.3	2.9
Retest	22	4.8	3.0
Post-test	22	4.5	2.4

Table 15

Repeated Measures ANOVA and Follow-ups by Occasion for CBI - Social Burden Scale Group Results

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	31.29	31.29	1.02	0.32		
Error	28	855.17	30.54				
Within Subjects Effects							
Time	2	0.88	0.44	0.41	0.66	0.66	0.66
Time x TRT+++	2	6.61	3.31	3.10	0.05	0.05	0.05
Error	56	59.77	1.07				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

Table 15 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
CBI1		
Pretest	1.50	0.15
CBI2		
Post-test/retest	0.44	0.67
CBI3		
Follow-up/post-test	1.01	0.32

was also used to examine the CBI social burden scores. The results of this analysis are reported in Table 16. This analysis was also not significant at the .05 level.

Hypothesis VI. Hypothesis VI stated there is no difference in perceived level of emotional burden for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the emotional burden scale of the Caregiver Burden Inventory (CBI). Means and standard deviations are reported in Table 17. As can be seen in Table 17, means on the CBI emotional burden scale for the treatment group were 4.7 (S.D. = 3.9) on the pre-test, 4.0 (S.D. = 3.2) on the post-test, and 3.3 (S.D. = 3.9) on the follow-up. Means for the control group were 5.0 (S.D. = 3.8) on the pre-test, 4.9 (S.D. = 3.3) on the retest prior to treatment, and 4.3 (S.D. = 3.6) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 18. As can be seen from this analysis, no significant difference was found between the treatment and control groups at the .05 level. Therefore, hypothesis VI was not rejected. There is no difference in perceived level of emotional burden following group participation as measured by the emotional burden scale of the CBI.

Table 16

ANCOVA - CBI - Social Burden Scale Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
Model	2	395.83	197.91	76.07	
Error	48	124.88	2.60		
Total	50	520.71			
Pre-CBI	1	392.29		150.78	0.0001
Treatment	1	8.26		3.17	0.0812

Table 17

Caregiver Burden Inventory Emotional Burden Scale Group Results

Group	N	Mean	Std. Dev.
<hr/>			
Treatment			
Pre-test	29	4.7	3.9
Post-test	29	4.0	3.2
Follow-up	8	3.3	3.9
Control			
Pre-test	22	5.0	3.8
Retest	22	4.9	3.3
Post-test	22	4.3	3.6

Table 18

Repeated Measures ANOVA and Follow-ups by Occasion for CBI - Emotional Burden Scale Results

Source	DF	Type	Mean	F	PR>F	Adj.	Adj.
		III ss	Square	Value		G-G+	H-F++

Between Subjects Effects

TRT+++	1	30.23	30.23	0.79	0.38		
Error	28	1074.26	38.37				

Within Subjects Effects

Time	2	2.92	1.46	0.86	0.43	0.39	0.40
Time x TRT+++	2	0.52	0.26	0.15	0.86	0.78	0.80
Error	56	94.79	1.69				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

Table 18 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
CBI1		
Pretest	0.89	0.38
CBI2		
Post-test/retest	0.96	0.34
CBI3		
Follow-up/post-test	0.70	0.49

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA) was also used to examine the CBI emotional burden scores. The results of this analysis are reported in Table 19. This analysis was also not significant at the .05 level.

Hypothesis VII. Hypothesis VII stated there is no difference in overall perception of caregiver burden for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the total CBI score. Means and standard deviations are reported in Table 20. As can be seen in Table 20, means on the total CBI scores for the treatment group were 24.9 (S.D. = 13.1) on the pre-test, 22.7 (S.D. = 12.2) on the post-test, and 24.1 (S.D. = 8.0) on the follow-up. Means for the control group were 23.4 (S.D. = 9.5) on the pre-test, 24.0 (S.D. = 10.0) on the retest prior to treatment, and 20.8 (S.D. = 9.4) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 21. As can be seen from this analysis, no significant difference was found between the treatment and control groups at the .05 level. Therefore, hypothesis VII was not rejected. There is no difference in overall perception of caregiver burden following group participation as measured by the total CBI score.

Table 19

ANCOVA - CBI - Emotional Burden Scale Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
Model	2	400.15	200.08	70.51	
Error	48	136.20	2.84		
Total	50	536.35			
Pre-CBI	1	390.59		137.65	0.0001
Treatment	1	5.38		1.90	0.1750

Table 20

Caregiver Burden Inventory Overall Burden Scale Results

Group	N	Mean	Std. Dev.
<hr/>			
Treatment			
Pre-test	29	24.9	13.1
Post-test	29	22.7	12.2
Follow-up	8	24.1	8.0
Control			
Pre-test	22	23.4	9.5
Retest	22	24.0	10.0
Post-test	22	20.8	9.4

Table 21

Repeated Measures ANOVA and Follow-ups by Occasion for CBI - Overall Burden Scale Results

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	9.70	9.70	0.04	0.85		
Error	28	6982.12	249.36				
Within Subjects Effects							
Time	2	18.07	9.04	1.45	0.24	0.24	0.24
Time x TRT+++	2	72.78	36.44	5.86	0.00	0.01	0.01
Error	56	348.17	6.22				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

Table 21 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
CBI1		
Pretest	0.14	0.08
CBI2		
Post-test/retest	0.42	0.67
CBI3		
Follow-up/post-test	0.88	0.38

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA) was also used to examine the CBI time-dependence scores. The results of this analysis are reported in Table 22. This analysis was also not significant at the .05 level.

Results of Hypothesis VIII through XIII - CRIS

Hypotheses VIII through XIII are presented below. All of these hypotheses were measured using scores obtained on the CRIS.

Hypothesis VIII. Hypothesis VIII stated there is no difference in stress monitoring for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the stress monitoring scale of the Coping Resources Inventory for Stress (CRIS). Means and standard deviations are reported in Table 23. As can be seen in Table 23, means on the CRIS stress monitoring scale for the treatment group were 68.9 (S.D. = 33.8) on the pre-test, 73.1 (S.D. = 28.9) on the post-test, and 72.9 (S.D. = 26.9) on the follow-up. Means for the control group were 74.5 (S.D. = 26.7) on the pre-test, 74.8 (S.D. = 26.8) on the retest prior to treatment, and 78.3 (S.D. = 22.0) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 24. As can be seen from this analysis, no significant difference was

Table 22

ANCOVA - CBI - Overall Burden Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
Model	2	4143.03	2071.52	46.58	
Error	48	2134.65	44.47		
Total	50	6277.69			
Pre-CBI	1	4118.85		92.62	0.0001
Treatment	1	82.89		1.86	0.1786

Table 23

Coping Resources Inventory for Stress - Stress Monitoring Scale
Group Results

Group	N	Mean	Std. Dev.
<hr/>			
Treatment			
Pre-test	29	68.9	33.8
Post-test	29	73.1	28.9
Follow-up	8	72.9	26.9
Control			
Pre-test	22	74.5	26.7
Retest	22	74.8	26.8
Post-test	22	78.3	22.0

Table 24

Repeated Measures ANOVA and Follow-ups by Occasion for CRIS - Stress Monitoring Scale Group Results

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	320.17	320.17	0.61	0.70		
Error	28	57462.3	2052.23				
Within Subjects Effects							
Time	2	189.11	94.56	1.68	0.20	0.20	0.20
Time x TRT+++	2	60.49	30.24	0.54	0.59	0.54	0.55
Error	56	3161.02	56.45				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

Table 24 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
CRIS1		
Pretest	0.46	0.65
CRIS2		
Post-test/retest	0.14	0.88
CRIS3		
Follow-up/post-test	0.57	0.58

found between the treatment and control groups at the .05 level. Therefore, hypothesis VIII was not rejected. There is no difference in stress monitoring following group participation as measured by the stress monitoring scale of the CRIS.

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA) was also used to examine the CRIS stress monitoring scores. The results of this analysis are reported in Table 25. This analysis was also not significant at the .05 level.

Hypothesis IX. Hypothesis IX stated there is no difference in self-disclosure for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the self-disclosure scale of the Coping Resources Inventory for Stress (CRIS). Means and standard deviations are reported in Table 26. As can be seen in Table 26, means on the CRIS self-disclosure scale for the treatment group were 70.0 (S.D. = 25.9) on the pre-test, 75.2 (S.D. = 27.5) on the post-test, and 71.3 (S.D. = 29.4) on the follow-up. Means for the control group were 68.0 (S.D. = 31.3) on the pre-test, 66.8 (S.D. = 29.8) on the retest prior to treatment, and 70.0 (S.D. = 28.9) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 27. As can

Table 25

ANCOVA - CRIS - Stress Monitoring Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
Model	2	35228.60	17614.30	257.44	
Error	48	3284.15	68.42		
Total	50	38512.75			
Pre-CRIS	1	35195.16		514.40	0.0001
Treatment	1	127.89		1.87	0.1779

Table 26

Coping Resources Inventory for Stress Self Disclosure Scale Group Results

Group	N	Mean	Std. Dev.
<hr/>			
Treatment			
Pre-test	29	70.0	25.9
Post-test	29	75.2	27.5
Follow-up	8	71.3	29.4
Control			
Pre-test	22	68.0	31.3
Retest	22	66.8	29.8
Post-test	22	70.0	28.9

Table 27

Repeated Measures ANOVA and Follow-ups by Occasion for CRIS - Self Disclosure Scale Results

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	61.38	61.38	0.02	0.88		
Error	28	73759.2	2634.26				
Within Subjects Effects							
Time	2	138.22	69.11	3.14	0.05	0.07	0.07
Time x TRT+++	2	147.56	73.78	3.35	0.04	0.06	0.06
Error	56	1232.36	22.00				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

Table 27 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
CRIS1		
Pretest	0.10	0.92
CRIS2		
Post-test/retest	0.46	0.65
CRIS3		
Follow-up/post-test	0.10	0.92

be seen from this analysis, a significant difference was found between the treatment and control groups by occasion at the .05 level before the values were corrected. This difference was not significant at the .05 level once the values had been corrected. Therefore, hypothesis IX was not rejected. There is no significant difference between the treatment and control groups in self-disclosure following group participation as measured by the self-disclosure scale of the CRIS across occasions.

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA) was also used to examine the CRIS self-disclosure scores. The results of this analysis are reported in Table 28. This analysis was significant at the .05 level.

Hypothesis X. Hypothesis X stated there is no difference in the caregiver's ability to organize and manage resources for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the structuring scale of the Coping Resources Inventory for Stress (CRIS). Means and standard deviations are reported in Table 29. As can be seen in Table 29, means on the CRIS structuring scale for the treatment group were 75.9 (S.D. = 23.2) on the pre-test, 105.2 (S.D. = 154.6) on the post-test, and 72.1 (S.D. = 23.2) on the follow-up. Means for the control group were 78.8 (S.D. = 16.9) on the

Table 28

ANCOVA - CRIS - Self Disclosure Scale Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
Model	2	38183.09	19091.55	360.58	
Error	48	2541.42	52.95		
Total	50	40724.51			
Pre-CRIS	1	37309.99		704.68	0.0001
Treatment	1	500.31		9.45	0.0035

Table 29

Coping Resources Inventory for Stress Structuring Scale Group Results

Group	N	Mean	Std. Dev.
<hr/>			
Treatment			
Pre-test	29	75.9	23.2
Post-test	29	105.2	154.6
Follow-up	8	72.1	23.2
Control			
Pre-test	22	78.8	16.9
Retest	22	78.5	16.3
Post-test	22	80.7	16.0

pre-test, 78.5 (S.D. = 16.3) on the retest prior to treatment, and 80.7 (S.D. = 16.0) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 30. As can be seen from this analysis, no significant difference was found between the treatment and control groups at the .05 level. Therefore, hypothesis X was not rejected. There is no difference in the caregiver's ability to organize and manage resources following group participation as measured by the structuring scale of the CRIS.

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA) was also used to examine the CRIS structuring scores. The results of this analysis are reported in Table 31. This analysis was also not significant at the .05 level.

Hypothesis XI. Hypothesis XI stated there is no difference in tension reduction for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the tension control scale of the Coping Resources Inventory for Stress (CRIS). Means and standard deviations are reported in Table 32. As can be seen in Table 32, means on the CRIS tension reduction scale for the treatment group were 60.8 (S.D. = 29.4) on the pre-test, 67.8 (S.D. = 28.2) on the post-test, and 61.3 (S.D. = 29.5) on the follow-up. Means for the control group

Table 30

Repeated Measures ANOVA and Follow-ups by Occasion for CRIS Structuring Scale Group Results

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	1185.83	1185.83	1.18	0.29		
Error	28	28151.2	1005.40				
Within Subjects Effects							
Time	2	50.65	25.33	2.68	0.08	0.09	0.08
Time x TRT+++	2	1.58	0.79	0.08	0.92	0.89	0.91
Error	56	529.06	9.45				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

Table 30 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
CRIS1		
Pretest	1.05	0.30
CRIS2		
Post-test/retest	1.02	0.31
CRIS3		
Follow-up/post-test	1.15	0.26

Table 31

ANCOVA - CRIS - Structuring Scale Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
<hr/>					
Model	2	51880.56	25940.28	1.97	
Error	48	631544.0	13157.17		
Total	50	683424.5			
Pre-CRIS	1	42934.78		3.26	0.0771
Treatment	1	11841.80		0.90	0.3475

Table 32

Coping Resources Inventory for Stress Tension Control Scale Group Results

Group	N	Mean	Std. Dev.
<hr/>			
Treatment			
Pre-test	29	60.8	29.4
Post-test	29	67.8	28.2
Follow-up	8	61.3	29.5
Control			
Pre-test	22	65.2	28.9
Retest	22	66.2	28.3
Post-test	22	72.2	23.7

were 65.2 (S.D. = 28.9) on the pre-test, 66.2 (S.D. = 28.3) on the retest prior to treatment, and 72.2 (S.D. = 23.7) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 33. As can be seen from this analysis, no significant difference was found between the treatment and control groups at the .05 level. Therefore, hypothesis XI was not rejected. There is no difference in tension reduction following group participation as measured by the tension control scale of the CRIS.

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA) was also used to examine the CRIS tension control scores. The results of this analysis are reported in Table 34. This analysis was also not significant at the .05 level.

Hypothesis XII. Hypothesis XII stated there is no difference in confidence for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the confidence scale of the Coping Resources Inventory for Stress (CRIS). Means and standard deviations are reported in Table 35. As can be seen in Table 35, means on the CRIS confidence scale for the treatment group were 66.1 (S.D. = 28.1) on the pre-test, 66.1 (S.D. = 30.6) on the post-test, and 54.0 (S.D. = 32.8)

Table 33

Repeated Measures ANOVA and Follow-ups by Occasion for CRIS Tension Control Scale Group Results

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	1297.80	1297.80	0.60	0.45		
Error	28	60594.6	2164.09				
Within Subjects Effects							
Time	2	545.85	272.92	3.62	0.03	0.05	0.05
Time x TRT+++	2	158.69	79.35	1.05	0.36	0.34	0.34
Error	56	4218.22	75.33				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

Table 33 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
CRIS1		
Pretest	0.85	0.40
CRIS2		
Post-test/retest	0.37	0.71
CRIS3		
Follow-up/post-test	1.05	0.30

Table 34

ANCOVA - CRIS - Tension Control Scale Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
<hr/>					
Model	2	32149.32	16074.66	111.35	
Error	48	6929.19	144.36		
Total	50	39078.51			
Pre-CRIS	1	32119.98		222.50	0.0001
Treatment	1	356.25		2.47	0.1228

Table 35

Coping Resources Inventory for Stress Confidence Scale Group Results

Group	N	Mean	Std. Dev.
<hr/>			
Treatment			
Pre-test	29	66.1	28.1
Post-test	29	66.1	30.6
Follow-up	8	54.0	32.8
Control			
Pre-test	22	78.5	19.1
Retest	22	75.9	22.7
Post-test	22	80.5	20.8

on the follow-up. Means for the control group were 78.5 (S.D. = 19.1) on the pre-test, 75.9 (S.D. = 22.7) on the retest prior to treatment, and 80.5 (S.D. = 20.8) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 36. As can be seen from this analysis, no significant difference was found between the treatment and control groups at the .05 level. Therefore, hypothesis XII was not rejected. There is no difference in confidence following group participation as measured by the confidence scale of the CRIS.

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA) was also used to examine the CRIS confidence scores. The results of this analysis are reported in Table 37. This analysis was also not significant at the .05 level.

Hypothesis XIII. Hypothesis XIII stated there is no difference in overall perception of coping resources for treatment and delayed treatment groups across the three occasions following group participation. This was measured by the coping resource effectiveness scale (overall coping resources score) of the Coping Resources Inventory for Stress (CRIS). Means and standard deviations are reported in Table 38. As can be seen in Table 38, means on the CRIS coping resource effectiveness scale for the treatment group

Table 36

Repeated Measures ANOVA and Follow-ups by Occasion for CRIS
Confidence Scale Group Results

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	11204.2	11204.2	6.82	0.01		
Error	28	46005.3	1643.05				
Within Subjects Effects							
Time	2	144.09	72.05	2.20	0.12	0.13	0.13
Time x TRT+++	2	14.49	7.25	0.22	0.80	0.74	0.76
Error	56	1833.22	32.74				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

Table 36 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
CRIS1		
Pretest	2.79	0.01
CRIS2		
Post-test/retest	2.31	0.03
CRIS3		
Follow-up/post-test	2.63	0.01

Table 37

ANCOVA - CRIS - Confidence Scale Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
<hr/>					
Model	2	33858.92	16929.46	186.95	
Error	48	4346.72	90.56		
Total	50	38205.65			
Pre-CRIS	1	32664.54		360.71	0.0001
Treatment	1	118.06		1.30	0.2592

Table 38

Coping Resources Inventory for Stress Overall Effectiveness Scale
Group Results

Group	N	Mean	Std. Dev.
<hr/>			
Treatment			
Pre-test	29	68.9	19.1
Post-test	29	72.0	19.1
Follow-up	8	64.5	21.7
Control			
Pre-test	22	72.4	15.6
Retest	22	71.9	15.6
Post-test	22	77.5	13.8

were 68.9 (S.D. = 19.1) on the pre-test, 72.0 (S.D. = 19.1) on the post-test, and 64.5 (S.D. = 21.7) on the follow-up. Means for the control group were 72.4 (S.D. = 15.6) on the pre-test, 71.9 (S.D. = 15.6) on the retest prior to treatment, and 77.5 (S.D. = 13.8) on the post-test.

To test this hypothesis, a repeated measures analysis of variance (ANOVA) was performed. Results of this analysis and follow-ups by occasion are reported in Table 39. As can be seen from this analysis, a significant difference was found between the treatment and control groups by occasion at the .05 level. Therefore, hypothesis XIII was rejected. There is a significant difference between treatment and control groups in overall coping resource effectiveness following group participation as measured by the coping resource effectiveness scale (overall coping score) of the CRIS across occasions. Furthermore, overall coping resource effectiveness significantly increased following group participation (i.e., the lone significant difference was at the end of phase I).

Because the total N was low on the third occasion (follow-up, N=8), a simple analysis of covariance (ANCOVA) was also used to examine the CRIS coping resource effectiveness scores. The results of this analysis are reported in Table 40. This analysis was also significant at the .05 level.

Table 39

Repeated Measures ANOVA and Follow-ups by Occasion for CRIS Overall Coping Scale Group Results

Source	DF	Type III ss	Mean Square	F Value	PR>F	Adj. G-G+	Adj. H-F++
Between Subjects Effects							
TRT+++	1	1939.00	1939.00	2.29	0.14		
Error	22	23757.4	848.48				
Within Subjects Effects							
Time	2	199.17	99.58	19.26	0.0001	0.0001	0.0001
Time x TRT+++	2	81.43	40.72	7.88	0.001	0.002	0.001
Error	56	289.48	5.17				

Note:

+G-G = Greenhouse-Geisser Correction

++H-F = Huynh-Feldt Correction

+++TRT = Treatment/Delayed treatment effect

Table 39 -- continued

Occasion	t	PR> t
Within Occasion Follow-up t-tests		
CRIS1		
Pretest	1.50	0.15
CRIS2		
Post-test/retest	1.09	0.29
CRIS3		
Follow-up/post-test	1.95	0.06

Table 40

ANCOVA - CRIS - Overall Effectiveness Group Results

Source	DF	Sum of Squares	Mean Square	F Value	PR > F
<hr/>					
Model	2	14869.56	7434.78	814.11	
Error	48	438.36	9.13		
Total	50	15307.92			
Pre-CRIS	1	14869.46		1628.20	0.0001
Treatment	1	16.81		153.50	0.0002

Summary of Chapter IV

The results have documented support for two of the hypotheses. There was a significant increase in knowledge of the aging process following group participation. There was a significant increase in overall coping resource effectiveness following group participation. No significant differences were found in caregiver burden or on the subscales of the CBI following group participation. Additionally, no significant differences were found on the subscales of the CRIS. However, equivocal results were found for the self-disclosure scale of the CRIS.

CHAPTER V DISCUSSION AND IMPLICATIONS

This study involved the development and implementation of a counseling intervention designed to meet the needs of midlife adult children caring for aging parents in three areas: knowledge, emotional support, and skill development. The effectiveness of this intervention was evaluated using an experimental research design. The results of the data analyses were presented in Chapter IV and are discussed in this chapter following a discussion of limitations of the study. Chapter V concludes with a discussion of implications for counseling and teaching, recommendations for further research, and conclusions.

Limitations of the Study

The discussion of the data is contingent upon limitations of the study; therefore, it is appropriate that these be discussed here before proceeding with a discussion of the results. These limitations are discussed in terms of sampling, instrumentation, and response error.

Because the sample for the proposed study is composed of midlife adult children caring for aging parents who reside in Alachua County, the sample is not necessarily representative of all adult children caring for aging parents. The use of a sample obtained in this area may

produce results which are not generalizable to large urban areas such as Miami or cities outside Florida. Furthermore, literature exists which suggests that different cultural groups provide caregiving in different ways. Although possible differences in caregiving provided by different cultural groups may influence group effectiveness, it was beyond the scope of this study to include cultural differences. Therefore, the results of this study can not be generalized to members of other cultural groups.

The use of volunteers may also create a sampling bias because the characteristics of people who volunteer may be different from those who do not. Because there is no way to know how those persons who volunteer may differ from those who do not without testing both groups, there is no way to measure the extent of the possibility of this bias. Additionally, because this study depended on voluntary participation, there was the possibility that some participants may not attend all group meetings or that they may drop out of the study before completion. Individuals who dropped out or did not attend all group meetings were not included in the final sample.

Another limitation of this study is that there was no way to control for group dynamics which may be a result of personal characteristics of the group leader. Because the same group leader was utilized in each group, these effects should be standard across the groups included in the study;

however, they may affect the outcomes of future groups utilizing different leaders.

Because this study was conducted using the self-report of each participant, there is the possibility of respondent biases. The questionnaires which were utilized in the study asked what behaviors the participant commonly uses to deal with stressful situations, what knowledge the participant possesses, and what the participant perceives as creating caregiver burden. It is assumed that the participant's responses are accurate within his or her experience or perception. There is no way to determine if the responses are not accurate, therefore, this is a possible source of bias.

Discussion of the Hypotheses

A total of thirteen hypotheses were explored in the current study. A discussion of the results obtained for each hypothesis is presented below.

Discussion of Hypothesis I

Hypothesis I stated that there is no difference in knowledge of the aging process following group participation as measured by the Facts on Aging Quiz - Revised.

Hypothesis I was not supported by the findings of the study. Upon analysis, a significant difference in knowledge of the aging process following group participation was found. An examination of the means provided evidence that there was a significant increase in knowledge as measured by the FAQ-R

following group participation. The significant differences following group participation were found using both repeated measures and simple ANCOVA analyses and were sustained at the four week follow-up.

Knowledge of the aging process is an essential component in understanding and caring for aging parents. If caregivers understand the normal aging process, they are better able to recognize changes in behavior and functioning of an aging parent which may be indicative of problems that need attention. For example, a parent who suddenly becomes confused and disoriented may be suffering from medication problems, mini-strokes, etc. If the caregiver does not know that sudden changes in mental state are not a function of the normal aging process, they may attribute such changes to "senility" and not seek appropriate intervention. If, however, a caregiver realizes that this sudden change is not a function of normal aging, the caregiver is much more likely to seek appropriate intervention (Clark & Rakowski, 1983; Miller, 1982; Smith, 1989).

Seeking appropriate intervention in a timely manner is important not only for the health and safety of the parent, but for the continued relationship between the caregiver and parent. As was previously discussed, adult children are the primary caregivers for aging parents and it is essential for interventions to assist them in caring more effectively for their parents in order to prevent premature

institutionalization. Knowledge of the aging process resulting in an increased ability to recognize age-related changes as well as abnormal changes, and therefore the increased ability to seek timely appropriate intervention may directly affect the caregiving relationship by allowing the parent to continue functioning at the highest possible level and reducing the responsibilities of the caregiver (Myers, 1989; Miller, 1982). However, it is important to note that an increase in knowledge does not necessarily indicate a direct change in behavior.

The purpose of including knowledge of the normal aging process in the treatment was to enhance the effectiveness of caregivers. The results of the data analysis indicate that the treatment was effective in increasing the knowledge of participants. This finding is particularly important not only for the positive impact on the caregiving relationship discussed above but also because most interventions designed to meet the needs of adult children caring for aging parents include a knowledge component (Clark & Rakowski, 1983; Miller, 1982; Remnet, 1987; Smith, 1989). Therefore, the finding that it is possible to increase knowledge of the aging process through the presentation of information has implications for future psychoeducation interventions. The current study provides support for the inclusion of a component which focuses on increasing knowledge of the aging process in future interventions designed to meet the needs

of this group. Additionally, this finding raises the question: If knowledge is increased, how much change in caregiver behavior occurs as a result of this increase in knowledge?

Discussion of Hypothesis II

Hypothesis II stated that there is no difference in perceived level of burden due to restrictions on the caregiver's time following group participation. This was measured by the time-dependence scale of the CBI. This hypothesis was not rejected.

The intervention developed and implemented in this study was designed to address the issue of time restriction directly and indirectly. Information was presented on relevant time management strategies during the third group session. Time management was also addressed indirectly in the third session through discussion generated during group brainstorming activities when caregivers shared various strategies they had found effective in addressing problems. Additionally, time management was addressed indirectly through the provision of information related to available community resources with the hope that this information would allow caregivers to access any resources they did not already utilize to reduce the tasks required of the caregivers and thereby reduce burden on the caregivers time.

The finding that the caregivers' perception of restrictions on their time due to caregiving did not change

significantly following group participation may be explained in several ways. First, caregivers were placing additional demands on their already limited time to attend the group once a week for 2 hours. Secondly, caregivers may not have had ample time to contact additional resources identified in the group and/or they may not have received access to those services by the time the post-tests were administered. Third, caregivers may not have had sufficient time to employ new ideas learned in the group long enough to feel any results before completing the post-test. It may take time for the caregiver to become proficient in new approaches learned in the group and therefore no difference was found. Fourth, any decrease in caregiver perception of time burden may have been negated by a heightened sense of awareness of the time they spend caregiving and the effects of caregiving on their lives created by attending the group.

Future studies may wish to address time management more directly by offering ways caregivers can assess their current time use and then providing alternative methods to manage time. Furthermore, an alternate measure of burden created by demands on caregiver time may need to be employed to find any differences and/or a greater length of time between group completion (or between completion of the time management section of the intervention) and the post-test may yield different results.

Discussion of Hypothesis III

Hypothesis III stated that there is no difference in perceived level of developmental burden following group participation. This was measured by the developmental burden scale of the CBI. This hypothesis was supported by an analysis of the data and was therefore not rejected.

The concept of developmental burden was recognized as an especially significant area of burden for mid-life adult children caring for aging parents. This is based on a review of the literature related to midlife which, as was previously discussed, suggested that adults at this stage in life may be coping with several issues related to their own development. These issues include a change in time perspective and an accompanying sense of urgency; a reexamination of one's life and goals; an effort to balance career, family, and civic responsibilities; an effort to develop a sense of filial maturity; and a resurfacing of identity and intimacy issues (Buehler, 1967; Erikson, 1963; Neugarten, 1968). Although the transitions of this period hold the potential for increased independence, self-direction, and pursuit of goals postponed during the child-rearing years, this potential may be altered as the needs of aging parents increase producing a heightened awareness of developmental burden for midlife caregivers (Myers, 1989).

The issue of developmental burden was addressed in the intervention during session IV through a lecture/group

discussion format. Differences and similarities in life tasks faced by both mid-life caregivers and their aging parents were discussed as well as implications for the caregiving situation. The position of "Sandwich Generation" and the impact of societal position was also discussed during this session.

Although it appeared from the discussions generated as a result of this topic that the caregivers gained an increased understanding of developmental issues and their implications for both themselves and their aging parents, the developmental burden scale of the CBI showed no significant change for the participants. This may be explained when one considers the scope of the issues of developmental burden. It may have been too optimistic to expect that following one group session addressing a topic such as developmental issues, a significant change in developmental burden could be realized. If an intervention is to affect such an encompassing issue, a group counseling and/or individual counseling approach may be more beneficial than the psychoeducational approach utilized in the present study. Additionally, a longer time interval between the intervention and the post-test may find a more significant impact in this area.

Discussion of Hypothesis IV

Hypothesis IV stated that there is no difference in perceived level of physical burden following group

participation. This was measured by the physical burden scale of the CBI. An analysis of the data found no significant difference in perceived physical burden as a result of group participation.

An assessment of physical burden was included in the current study; however, no direct attempts were made during the intervention to address physical burden. Physical burden was addressed indirectly in the third session as a component of stress management. Getting enough rest, eating well, and exercising were emphasized as ways to reduce stress, gain energy, and stay physically fit to meet the challenges of the caregiving role. Additionally, strategies for completing tasks which involved physical activity were addressed by participants during group discussions.

The fact that perceived physical burden showed no significant change following group participation may be due to the fact that the physical tasks required of the caregiver did not change appreciably during the four weeks of group participation. Unless caregivers had the time and/or necessity to access additional services such as a personal care worker or nursing home placement, physical tasks required were basically unchanged by group participation and therefore, did not show any difference upon reassessment.

Discussion of Hypothesis V

Hypothesis V stated that there is no difference in

perceived level of social burden following group participation. This was measured by the social burden scale of the CBI. An analysis of the data indicated that there was no significant change in perceived social burden following group participation.

Social burden describes the caregiver's perception of burden due to feelings of role conflict. Social burden was addressed in Session II through small group discussions initiated by stimulus questions. Caregivers expressed feelings of role conflict related to the demands on their time made by children, spouses, friends, and relatives as well as by the care receiver. Many caregivers expressed feelings that although they recognized the demands made by significant others for their time, the demands of the caregiving relationship took priority and therefore, the other relationships suffered. Furthermore, several caregivers expressed feelings of resentment toward siblings who did not share in the care of the parent.

Although caregivers seemed to gain an awareness of feelings of social burden and role conflict, it was beyond the scope of the current intervention to address these needs in more depth. The lack of change in feelings of social burden following group participation may have been due to the lack of further group counseling and/or individual counseling in this area which could have been designed to

assist caregivers in identifying and implementing strategies to reduce feelings of role conflict. Future interventions may be designed to address this area in further depth.

Discussion of Hypothesis VI

Hypothesis VI stated that there is no difference in perceived level of emotional burden following group participation. This was measured by the emotional burden scale of the CBI. An analysis of the data found no significant differences in perception of emotional burden following group participation. Hypothesis VI was not rejected.

Emotional burden, as measured by the CBI, was defined as the caregiver's perception of burden due to the caregiver's negative feelings toward their care receiver. Given the psychoeducational nature of the current study as well as the time constraints, it was difficult to establish an environment where caregivers felt comfortable expressing negative feelings toward their care receiver. Although caregivers expressed feelings of fatigue and anger, the questions on the CBI addressed feelings of embarrassment and shame directed at the care receiver. Caregivers did not seem willing to discuss these types of negative feelings directed at the care receivers in the group climate created by this intervention. However, they did seem willing to express negative feelings toward the caregiving relationship. For example, rather than saying "I resent my

care receiver.", caregivers in the group might have said "It makes me angry that I have to provide care to my mother and I don't have time to do anything else." In this way, caregivers were not expressing negative feelings toward the caregiver but rather toward the situation. It appeared that this was a safer expression of negative feelings in the current intervention setting.

Future interventions designed to address this variable may need to incorporate a design based more on group counseling. Merely touching on these issues in the current psychoeducational intervention did not seem to directly impact feelings of emotional burden. Additionally, the way in which emotional burden was defined by the subscale of the CBI may not have been the most appropriate measure of perception of emotional burden. Additional measures of this construct may need to be identified and incorporated in future studies.

Discussion of Hypothesis VII

Hypothesis VII stated that there is no difference in overall perception of caregiver burden following group participation. This was measured by the overall score on the CBI. Data analysis showed no significant difference in caregiver perception of overall burden as measured by the CBI.

Caregiver perception of burden was addressed in several ways in the current intervention. However, the emphasis in

the current intervention was to assist caregivers in recognizing feelings of caregiver burden and allowing caregivers an opportunity to realize these feelings as "normal." The psychoeducational nature of the intervention did not allow for group and/or individual counseling approaches which may have addressed these feelings in such a way as to facilitate exploration of the feelings and help caregivers to identify and implement strategies designed to minimize feelings of burden.

Although caregiver burden has been identified in the literature as a primary issue for midlife adult children caring for aging parents and is often included as an area to be addressed in caregiver intervention strategies, no significant difference in the perception of burden was found using the current psychoeducational intervention and the CBI. Subjective impressions of the researcher supported the importance of the issue of caregiver burden among mid-life adult children caring for aging parents. Therefore, it would seem that future interventions should continue to address caregiver burden; however, counselors developing these interventions may need to utilize a different approach and/or a different outcome measure.

Discussion of Hypothesis VIII

Hypothesis VIII stated that there is no difference in stress monitoring following group participation. This was

measured by the stress monitoring scale of the CRIS. Analysis of the data found no significant difference in stress monitoring following group participation; therefore, this hypothesis was not rejected.

Stress management was included as a major component of the current intervention based upon a review of the literature which suggested that emotional stresses are consistently reported as the most pervasive and most difficult aspect of caregiving (Cantor, 1983; Cicirelli, 1980; Haley et al., 1987). Stress was addressed both directly and indirectly in the intervention. The stress response was discussed and participants were taught how to identify stressors in their own lives as well as to identify the feelings of stress in their own bodies. Different methods of stress management were also addressed and participants took part in a practice session of progressive relaxation.

There are several reasons why no difference was found on this variable following group participation. First, stress monitoring is defined as an evaluative dimension of the respondent's awareness of personal stress and tension build-up and awareness of situations and events which are likely to prove stressful. This definition may not have been helpful in the current study because caregivers were already very aware of the stresses they were experiencing and the events (caregiving) which were precipitating these

stresses. Therefore, even though stress was addressed and interventions taught, caregivers may not have changed significantly in their awareness of stresses which is what this scale measures.

Second, stress management strategies were taught in the third group session. The post-test was given only a week later following completion of the fourth session. This was a very short time interval for caregivers to begin practicing new stress management techniques and to realize full benefit from them. Stress management techniques are skills which take time and practice to develop. Therefore, caregivers may have learned new stress management skills and may not have had time to realize the full benefits of these strategies.

Third, as discussed above, stress management strategies require practice and skill development. This time-limited, psychoeducational intervention may not have addressed these skills in enough depth to significantly alter caregivers perceptions of stress and stress management skills.

Future intervention may need to include additional measures of stress monitoring and management. Also, these interventions may spend more time teaching and practicing stress management techniques. Finally, it is important to allow enough time for participants to incorporate these new techniques into their stress management approaches before measuring the impact of such techniques.

Discussion of Hypothesis IX

Hypothesis IX stated that there is no difference in self-disclosure following group participation. This was measured by the self-disclosure scale of the CRIS. An analysis of the data indicated that there was a significant difference in self-disclosure following group participation before the values were corrected using the repeated measures analysis, after which the values were not significant at the .05 level. The results of the ANCOVA were significant at the .05 level. Therefore, because the results were equivocal, this hypothesis was not rejected. A further examination of the means shows an increase in self-disclosure following group participation. This effect was not sustained upon four week follow-up.

The self-disclosure scale of the CRIS measures an evaluative dimension of the respondent's willingness to share honestly his or her feelings, thoughts, and opinions with others. Although self-disclosure was not addressed directly in the group, participants were encouraged to share their thoughts and feelings in the group setting. Many participants indicated they had never participated in a group and/or they had never participated in any type of counseling. Furthermore, most participants indicated they felt the most valuable component of the intervention was the opportunity to share feelings and "normalize" them within

the group. Therefore, one would expect scores on this subscale to increase following group participation.

It is important to note here that many participants continued to meet following the final group meeting. This researcher did not request that participants continue to meet nor did the researcher ask participants to share telephone numbers, etc. However, in all five groups at least some of the participants exchanged telephone numbers and two groups continued to meet following the last session. The purpose of both of these activities was to continue the opportunity for support and sharing among caregivers. Future interventions could include suggestions from the leader that participants may wish to exchange numbers or continue to meet as a support group. Also, a goal of future interventions may be to begin with a time-limited, structured group and progress into a continuous, leaderless, support group.

The finding that the effect was not sustained upon follow-up could be due to characteristics of the limited number of persons responding to the follow-up. Those persons who responded to the follow-up questionnaires may not have been participating in the continued support groups and may have felt their ability to self-disclose was again limited without the group.

Discussion of Hypothesis X

Hypothesis X stated that there is no difference in the

caregiver's ability to organize and manage resources following group participation. This was measured by the structuring scale of the CRIS. An analysis of the data indicated no significant changes in structuring following group participation therefore, this hypothesis was not rejected.

The ability to organize and manage resources (structuring) was addressed indirectly in the current intervention. This occurred through the discussion of time management strategies and available community resources. No effort was made in this time-limited, psychoeducational approach to directly increase the caregiver's ability to organize and manage resources. This was beyond the scope of the current study. Therefore, it seems to follow that there was no significant change on this variable following group participation.

Discussion of Hypothesis XI

Hypothesis XI stated that there is no difference in tension reduction following group participation. This was measured by the tension control scale of the CRIS. An analysis of the data found no significant difference in tension control following group participation; therefore, this hypothesis was not rejected.

Tension control, as defined by the CRIS, is an evaluative dimension of the respondent's ability to measure

the degree of ability to lower arousal through relaxation procedures and thought control. As discussed above in relation to the stress monitoring scale, stress management techniques require practice for skill development. The current intervention did include a session on stress management and a practice session of progressive relaxation; however, this was only provided participants with a small amount of knowledge regarding stress management techniques and did not include extensive practice or discussion of techniques. Also, the post-test was administered following the fourth session which was approximately one week after the stress management session. This may not have allowed ample time for participants to become proficient in new stress management techniques even if they had been practicing them at home after discussing them in the group.

Many participants commented to the researcher that they found the progressive relaxation exercise very beneficial and requested copies of the audiotape utilized in class. These were distributed following completion of the final series of questionnaires so as not to contaminate the findings. Therefore, future interventions may wish to include a more extensive section on stress management which allows for exploration and practice of different stress management strategies.

Discussion of Hypothesis XII

Hypothesis XII stated that there is no difference in

confidence following group participation. This was measured by the confidence scale of the CRIS. An analysis of the data showed no significant difference in confidence following group participation, therefore, this hypothesis was not rejected.

Confidence, as defined in the CRIS, is an evaluative dimension of the respondent's ability to measure his/her ability to cope successfully with stress. This scale was included in the current study to measure any changes in the respondent's perception of their ability to manage stress whether or not they had actually mastered new stress management skills. It is interesting to note that group participants' perception of their ability to cope successfully with stress did not change following group participation.

This may be due to a variety of factors. As previously discussed, participants may not have had enough time to practice new techniques and to begin to feel more confident in their ability to manage stress. The group may not have provided the participants with enough opportunity to explore new stress management techniques. Additionally, some caregivers may have been so overwhelmed by stress that even though the stress management information increased their ability to handle stress, it did not have enough impact to change their overall perception of their ability to deal

with stress. Again, future interventions may need to include more emphasis on stress management techniques as this area has been identified as the most difficult for caregivers.

Discussion of Hypothesis XIII

Hypothesis XIII stated that there is no difference in overall perception of coping resources following group participation. This was measured by the coping resources effectiveness scale of the CRIS. An analysis of the data showed a significant difference in overall perception of coping resources following group participation; therefore, this hypothesis was rejected. Further examination of the means showed a significant increase in overall perception of coping resources following group participation on the post-test. However, there was a decrease in overall perception of coping resources on the follow-up testing. This may have been due to the low return rate of the follow-up questionnaires. It may also have indicated that following the completion of the group, participants once again began to feel stressed and the positive effects of the group were negated, particularly for those individuals who did not continue to meet in some way with other group participants. Those persons who continued to meet may have experienced continued support and the opportunity to vent their feelings and frustrations providing them with a continued sense of increased coping resources.

It is particularly interesting to note that, although the participants' perceptions of increased ability to deal with stress did not show a significant change as measured by the subscales of the CRIS, their overall perception of coping resources increased significantly following group participation. This may have been due to the effects of being in a group, specific information and skills gained from the treatment, or a combination of these factors.

The intervention tested in this study appeared to be successful in increasing overall perception of coping resources. Future interventions may need to address specific areas of coping in more detail. Additionally, future interventions may need to focus on assisting participants in sustaining the positive effects of group participation.

Summary of the Discussion

It appears that the time-limited, psychoeducational intervention developed and implemented in the current study was successful in (a) increasing caregiver's knowledge of the aging process; (b) increasing caregiver's ability to self disclose; and (c) increasing caregiver's overall perception of coping resources. The treatment was not successful in (a) increasing specific coping skills; and (b) affecting caregiver's perception of burden. The results of the study seem to indicate that the time-limited, psychoeducational nature of the intervention may have

prevented caregivers from experiencing any changes in burden and/or coping skills. These problems may be addressed in future interventions by allowing more time for practice of specific coping and stress management skills. Additionally, it may be beneficial to structure future interventions to include a group or individual counseling component. This may affect caregiver perception of burden. Many participants in the current intervention expressed a need to participate in group counseling while participating in the current study. Although this may have been the most beneficial and appropriate way to handle issues which surfaced during the intervention, participants were told that this was not a part of the current study and they would be referred to additional resources following completion of the study if they so desired. Additionally, they were told that they could be referred for counseling immediately if they felt that was necessary. However, no participants left the group to attend counseling while the group was ongoing. Also, no participants who were included in the final data sample indicated a significant change in the caregiving relationship while participating in the intervention.

It is interesting to note that the resulting sample consisted mainly of white females as would have been predicted based on the review of the literature. Additionally, these females were caring mainly for mothers and had identified themselves as the primary caregivers.

Implications

Despite the recognition that adult children are the primary caregivers to aging parents, there have been relatively few interventions proposed to meet the needs of this group. There have been even fewer studies which have attempted to assess the effectiveness of interventions for adult children caring for aging parents. The researcher through this study attempted to accomplish both of these purposes. The outcomes of this research have implications for adult children, aging parents, families, society, counselors, counselor educators, and future research.

More specifically, the researcher focused on the needs of adult children in three areas: knowledge, emotional support and skill development. Through increased knowledge of community resources and the aging process, provision of emotional support, and development of stress reduction techniques and coping strategies; this intervention allowed adult children to better meet their own needs as well as the needs of their aging parents. This is particularly important given the fact that adult children provide the majority of care for older persons in the community.

Additionally, this intervention benefitted older persons through provision of an intervention which better prepares children to assist them with necessary activities. This allows aging parents to have their needs met and to remain as independent as possible, thus avoiding premature

institutionalization. Adult children and aging parents are both members of a larger group, the family. Therefore, this study has implications for families as well. By decreasing stress and increasing communication, more positive family relationships may result between all family members.

This study also has implications for society as a whole. As previously discussed, adult children perform a vital role in society, that of parent care. As the number of older persons requiring care continues to increase, society must rely more heavily on adult children to fill the caregiving role. Therefore, development and implementation of interventions designed to assist adult children in fulfilling the caregiving role directly benefit society.

Additionally, the present study has direct implications for counselors. If effective counseling interventions can be developed and tested which meet the needs of adult children caring for aging parents, then these interventions will form a basis for counselors working with this population. Furthermore, as the population of adult children caring for aging parents continues to increase, counselors will need to possess knowledge related to the unique needs of this population and counseling interventions which are effective in meeting these needs. Therefore, this study has implications for counselor educators who are preparing counselors for the future when an even larger

proportion of the population may experience counseling needs related to caring for aging parents.

Finally, this study has implications for future research. Several additional questions that may be addressed include Is this the most effective way to meet the needs of this population? Are there more effective ways to meet the needs of this population and what are they? Is this intervention particularly effective for individuals experiencing a particular type of situation and, if so, what type of situation? Are the results of the study replicable? Were the correct outcome measures employed to measure effectiveness in the current study?

In summary, the intervention which was developed and tested in this study was an attempt to fill a gap in the existing literature related to interventions for mid-life adult children caring for aging parents. It is only a beginning, and hopefully it will stimulate much more needed research in this growing area of concern.

APPENDIX A
INFORMED CONSENT

I agree to participate in the research explained below:

The aim of this study is to evaluate the effectiveness of a counseling group which focuses on the needs of adult children of aging parents. The information collected in this study will be used to develop better ways for counselors to meet the needs of adult children caring for aging parents. The names of those who take part in this study will not be included in any report. All information shared in the group sessions will be kept confidential. To participate in this study, I will need to:

1. Complete a demographic information form, and three paper-and-pencil forms.
2. Attend four groups meetings which will include lectures, group discussions, and group activities.
3. Complete three paper-and-pencil forms at the completion of the groups.

I will feel free to ask any questions which I may have at any time.

The above stated nature and purpose of this research have been explained to me. Furthermore, I understand that this investigation may be used for educational purposes which may include publication. I also understand that I may withdraw my consent at any time without prejudice.

signed _____

APPENDIX B

LETTER TO PARTICIPANTS

I am a doctoral student in the Counselor Education Department of the University of Florida. I am conducting a study developed to evaluate the effectiveness of a group counseling approach designed to meet the needs of adult children caring for aging parents. I, myself, am caring for an aging parent and know that it requires additional adaptation to fulfill the many roles we are expected to perform and still have time for ourselves.

The study consists of four, 2 hour, group sessions designed to meet the needs of adult children caring for aging parents in several areas including: the normal aging process, available community resources, communication and relaxation skills, and issues related to mid and late life.

Participants must be between 30 and 70 years of age, caring for an aging parent at least 60 years of age, and not currently participating in therapy designed to meet the needs of adult children caring for aging parents.

Participation in the study includes completion of four questionnaires which have been included with this letter. All responses will be anonymous with each person receiving a code number.

Due to the nature of the research, results of the three questionnaires will not be available until the completion of the research. However, once the research is completed, you may contact me to discuss the results of the questionnaires you complete during the course of group participation.

If you are interested in participating in this study, please read and sign the enclosed consent form, complete the demographic information form, and the three questionnaires and bring these to our first group meeting. Completion of the questionnaires before the first group meeting is essential to group participation.

Thank you for your interest in this research study. I look forward to seeing you in the group.

Sincerely,

Valerie Babb Stewart

DEMOGRAPHIC INFORMATION

1. Age: _____
2. Gender: _____ Male _____ Female
3. Ethnic Origin (optional): _____
4. Are you employed? _____ yes _____ no
_____ full-time _____ part-time
5. Has caregiving affected your work? _____ yes _____ no
If yes, how has it affected your work?

- 200

The following information relates to your parent:

14. Age: _____

15. Place of residence: _____ resides with caregiver
_____ resides in own home _____ other (explain)

16. Description of impairment: _____

17. Are you currently or have you ever participated in any additional programs, either group or individual, designed to meet the needs of adult children caring for aging parents? _____ yes _____ no

18. Are you currently participating or have you ever participated in counseling, either group or individual? _____ yes _____ no

Subject number: _____

APPENDIX D

FACTS ON AGING QUIZ (REVISED)

PLEASE READ THE FOLLOWING ITEMS AND MARK EITHER "TRUE" OR "FALSE".

	TRUE	FALSE
1. THE MAJORITY (MORE THAN HALF) OF OLDER PEOPLE ARE SENILE. (DEFECTIVE MEMORY, DISORIENTED, DEMENTED, ETC.)	_____	_____
2. ALL FIVE SENSES TEND TO DECLINE IN OLD AGE.	_____	_____
3. THE MAJORITY (MORE THAN HALF) OF OLDER PERSONS HAVE NO CAPACITY FOR SEXUAL RELATIONS.	_____	_____
4. LUNG CAPACITY TENDS TO DECLINE IN OLD AGE.	_____	_____
5. THE MAJORITY OF OLDER PEOPLE SAY THEY ARE HAPPY MOST OF THE TIME.	_____	_____
6. PHYSICAL STRENGTH TENDS TO DECLINE IN OLD AGE.	_____	_____
7. AT LEAST ONE-TENTH OF THE AGED ARE LIVING IN LONGSTAY INSTITUTIONS (I.E. NURSING HOMES, MENTAL HOSPITALS, HOMES FOR THE AGED, ETC.).	_____	_____
8. DRIVERS OVER 65 HAVE MORE ACCIDENTS PER PERSON THAN DRIVERS UNDER AGE 65.	_____	_____
9. OLDER WORKERS CANNOT WORK AS EFFECTIVELY AS YOUNGER WORKERS.	_____	_____
10. ABOUT 80% OF OLDER PEOPLE SAY THEY ARE HEALTHY ENOUGH TO CARRY OUT THEIR NORMAL ACTIVITIES.	_____	_____
11. THE MAJORITY OF OLDER PEOPLE ARE UNABLE TO ADAPT TO CHANGE.	_____	_____
12. OLDER PEOPLE USUALLY TAKE LONGER TO LEARN SOMETHING NEW.	_____	_____
13. THE REACTION TIME OF OLDER PEOPLE TENDS TO BE SLOWER THAN REACTION TIME OF YOUNGER PEOPLE.	_____	_____

- | | | | |
|-----|--|-------|-------|
| 14. | IN GENERAL, OLD PEOPLE ARE PRETTY
MUCH ALIKE. | _____ | _____ |
| 15. | THE MAJORITY OF OLDER PEOPLE SAY THEY
ARE USUALLY BORED. | _____ | _____ |
| 16. | THE MAJORITY OF OLDER PEOPLE SAY THEY
ARE LONELY. | _____ | _____ |
| 17. | OLDER WORKERS HAVE MORE ACCIDENTS THAN
YOUNGER WORKERS. | _____ | _____ |
| 18. | OVER 15% OF THE U.S. POPULATION ARE NOW
AGE 65 OR OVER. | _____ | _____ |
| 19. | THE MAJORITY OF MEDICAL PRACTITIONERS
GIVE LOW PRIORITY TO OLDER PEOPLE. | _____ | _____ |
| 20. | THE MAJORITY OF OLD PEOPLE HAVE INCOMES
BELOW THE POVERTY LEVEL (\$3,025 FOR
A PERSON OR \$3,650 FOR COUPLES). | _____ | _____ |
| 21. | THE MAJORITY OF OLDER PEOPLE SAY THEY
WOULD LIKE TO HAVE SOME KIND OF WORK
TO DO. | _____ | _____ |
| 22. | OLDER PEOPLE TEND TO BECOME MORE
RELIGIOUS AS THEY AGE. | _____ | _____ |
| 23. | THE MAJORITY OF OLDER PEOPLE SAY THEY
ARE USUALLY IRRITATED OR ANGRY. | _____ | _____ |
| 24. | THE HEALTH AND SOCIOECONOMIC STATUS OF
OLDER PEOPLE (COMPARED TO YOUNGER
PEOPLE) IN THE YEAR 2000 WILL PROBABLY
BE ABOUT THE SAME AS NOW. | _____ | _____ |

APPENDIX E

CAREGIVER BURDEN INVENTORY (CBI)

Please read each statement below and rate each item from 0 (not at all descriptive) to 4 (very descriptive) by circling the appropriate number.

1. My care receiver needs my help to perform many daily tasks.

0 1 2 3 4

2. My care receiver is dependent on me.

0 1 2 3 4

3. I have to watch my care receiver constantly.

0 1 2 3 4

4. I have to help my care receiver with many basic functions.

0 1 2 3 4

5. I don't have a minute's break from my caregiving chores.

0 1 2 3 4

6. I feel that I am missing out on life.

0 1 2 3 4

7. I wish I could escape from this situation.

0 1 2 3 4

8. My social life has suffered.

0 1 2 3 4

9. I feel emotionally drained due to caring for my care receiver.

0 1 2 3 4

10. I expected that things would be different at this point
in my life. 0 1 2 3 4

11. I'm not getting enough sleep.

0 1 2 3 4

12. My health has suffered.

0 1 2 3 4

13. Caregiving has made me physically sick.

0 1 2 3 4

14. I'm physically tired.

0 1 2 3 4

15. I don't get along with other family members as well as I
used to. 0 1 2 3 4

16. My caregiving efforts aren't appreciated by others in my
family. 0 1 2 3 4

17. I've had problems with my marriage.

0 1 2 3 4

18. I don't do as good a job at work as I used to.

0 1 2 3 4

19. I feel resentful of other relatives who could but do not
help.

0 1 2 3 4

20. I feel embarrassed over my care receiver's behavior.

0 1 2 3 4

21. I feel ashamed of my care receiver.

0 1 2 3 4

22. I resent my care receiver.

0 1 2 3 4

23. I feel uncomfortable when I have friends over.

0 1 2 3 4

24. I feel angry about my interactions with my care receiver.

0 1 2 3 4

APPENDIX F

SHORT QUESTIONNAIRE

1. Has your caregiving situation changed significantly since the beginning of group participation? (For example, parent placed in a nursing home, parent moved in with you, parent's physical impairment changed.)

_____ no _____ yes

If yes, please explain:

2. Have you experienced any significant changes in your daily life since the beginning of group participation? (For example: loss of job, major illness, child leaving home.)

no _____ yes _____

If yes, please explain:

APPENDIX G BIOLOGICAL CHANGES

The handout related to biological changes associated with aging included the declines which occur in every body system beginning with visual changes in the mid-twenties. These changes are reflected in the older adult's reduced physical ability to adapt to many of these changes, and they may predispose an individual to both acute and chronic illness. The cumulative effect of these age-related changes has an impact on the total life of the individual. More specifically changes in body systems which were covered included:

I. Skin

- A. Less elastic and more wrinkled.
- B. Hair turns grey.
- C. Facial hair increases especially in women.
- D. Loss of pigmentation creates "aging" spots.

II. Musculoskeletal System

- A. Muscles atrophy.
- B. Joints undergo degenerative changes.
- C. Bones deteriorate and become brittle.
- D. Reaction time and reflex action slows.

III. Nervous System

- A. Progressive loss of neurons throughout life and brain weight decreases.
- B. Poor circulation.
- C. Personality changes do occur with advancing age.

- D. Cognitive changes do occur, but are not a reflection of declining intelligence.

IV. Respiratory System

- A. Decrease in maximum breathing capacity.
- B. Increased shortness of breath on exertion.
- C. Pulmonary diseases become increasingly prevalent.
- D. Chronic respiratory symptoms are not normal.

V. Cardiovascular System

- A. Cardiac reserve diminishes.
- B. Cardiac output decreases, heart rate decreases.
- C. Maximum blood flow decreases by 35% at age 60.
- D. Degenerative vascular disease is age-related.

VI. Gastrointestinal System

- A. Common cause of chronic distress, most complaints are functional rather than organic.
- B. Changes in bowel habits are common as is constipation.
- C. Changes are affected by poor teeth and dentures.
- D. Poor nutritional intake is common compounded by sensory changes in taste and smell.

VII. Genito-urinary System

- A. Changes in sexual responsiveness but physical capability remains.
- B. Diminished muscle tone.
- C. Increased frequency of urination.
- D. Prostate gland problems.

Sensory Changes were also included in this discussion. A summary follows in outline form.

I. Vision

- A. 7% of persons aged 65-75 have blindness or other visual impairment.
- B. 65% of persons aged 75+ have visual impairments
- C. Visual disorders result in poor mobility, poor spatial orientation, and sometime visual hallucinations.

II. Hearing

- A. Hearing loss affects more people than any other chronic condition.
- B. Hearing loss may be conductive or sensorineural.
- C. Hearing aides may or may not be helpful.

III. Touch

- A. Decreased touch sensations.
- B. Difficulty manipulating objects.
- C. Decreased response to touch.
- D. Causes of reduced sensations.

IV. Taste and Smell

- A. Number of taste buds declines.
- B. Sweet and salty flavor identification disappears.
- C. 40% of people have trouble with smell by 80.
- D. Since smell is related to appetite, appetite may decrease.
- E. Women retain the ability to identify substances

longer than men.

F. Obese people are better able to identify taste.

(References with may be helpful include: Continuing Education in Aging for Counselors: A Trainer's Manual by Jane E. Myers, 1986; Federal Council on Aging, 1978).

APPENDIX H COMMUNICATION SKILLS

Information presented in this session included information adapted from Gerard Egan in the book The Skilled Helper, pp. 61-77. Basically the handout included information on building communication skills. It began with a discussion of attending behaviors and facilitative responses. A discussion of the levels of responses was also given. For example a level 1 response the individual has some deficiency whereas a level 2 response shows respect for the older person and his or her world view, and the third level shows respect and also understanding. Then, participants were asked to rate responses based on these levels to several situations. Next, participants were asked to write appropriate responses to stimulus situations. A discussion of this activity followed and each dyad was given the opportunity to try a role play using these responses.

APPENDIX I
STRESS AND TIME MANAGEMENT

Information used in teaching stress management came from several sources. The book, Managing Stress by Jere Yates, 1979 was particularly helpful. Also, Stress Management by James Archer, 1990 offers many helpful incites into stress and time management. Several audio tapes are available which provide scripts for progressive relaxation which can be purchased at local book stores.

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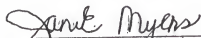
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BIOGRAPHICAL SKETCH

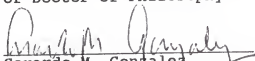
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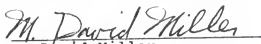
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